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State Retiree Health Plan Spending

An examination of funding trends and plan provisions

This report is a collaboration between the State Health Care Spending Project and The Pew Charitable Trusts' public sector retirement systems project.

The State Health Care Spending Project, an initiative of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, helps policymakers better understand how much money states spend on health care, how and why that amount has changed over time, and which policies are containing costs while maintaining or improving health outcomes.

For additional information, visit pewtrusts.org/healthcarespending.

The Pew Charitable Trusts' public sector retirement systems project performs research on all aspects of state and city public pension systems, including fiscal health, investment practices, benefits design, retiree health care, and governance, and offers technical assistance as they undertake reforms.

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Overview

All states, with the exception of Idaho, offer newly hired public workers access to certain retiree health care coverage as part of their benefits package.[1] Thirty-eight of these states have committed to making contributions toward health care premiums for such coverage. Retiree health coverage for these state government workers stands in sharp contrast to the private sector, where the proportion of firms with 200 or more workers offering health coverage to retirees has plummeted from 66 percent in 1988 to 28 percent in 2013.[2] Rising health care costs, changes in accounting standards for reporting the cost of retiree health benefits, competition from overseas firms and small startup companies, and the addition of prescription drug coverage to the Medicare program have contributed to this drop in private sector retiree health benefits. And although facing many of these same circumstances, most states continue to offer health benefits to their retired public workers, in an effort to help attract and retain a talented workforce.[3]

One of the most significant changes for the states was an adjustment the Governmental Accounting Standards Board (GASB) made to accounting standards that requires states to report liabilities for retiree benefits other than pensions—known as other post-employment benefits (OPEB)—in their financial statements. (See "Glossary" box.)[4] By December 2008, all state governments were required to implement these changes, and the increased financial transparency that resulted prompted states to take a closer look at OPEB obligations and how to fund and pay for them.[5] Retiree health insurance benefits account for the majority of states' OPEB obligations, so many states have implemented policy changes concerning these benefits to address looming OPEB obligations.[6] As a result, most states provide varying levels of retiree benefits based on factors such as date of hire, date of retirement, or vesting eligibility. (See Appendices A and D for more information about which groups of retirees were included in this study and why.)

This report, a first-of-its-kind effort, provides data on state OPEB liabilities—the cost in today's dollars of benefits to be paid to current workers and retirees over future years—and funding trends and how they are affected by aspects of state retiree health plans. Researchers collected and analyzed updated OPEB financial data and trends since 2010, as well as 50-state data on the eligibility criteria for retiree health plans. (To convey more clear and consistent trends, we report 50-state OPEB data only since 2010, because many states were adjusting to newly implemented GASB reporting standards in 2008 and 2009.) They found that states' strategies for addressing OPEB liabilities vary greatly and that the methods states choose to contribute to their retirees' health insurance premiums substantially affect the size of their OPEB liabilities. Specifically, the researchers found:

- States' OPEB liabilities decreased 10 percent, to $627 billion, between 2010 and 2013, after adjusting for inflation. This drop resulted from lower rates of growth in health care costs and changes states made to their OPEB funding policies and retiree health plan provisions.
- State-funded ratios—representing the amount of assets states have set aside to fund their OPEB liabilities—increased from 5 percent in 2010 to 6 percent in 2013.[7] However, this trend varied greatly among states—the funded ratio of eight states decreased, and Oregon increased its funded ratio by 25 percentage points.
- States' actual expenditures for OPEB totaled $18.4 billion in 2013, or 1.6 percent of state-generated revenue. (See "Glossary" box.) If states had instead set aside the amount suggested by actuaries to pay for OPEB liabilities, their total payments that year would have more than doubled to $48 billion—4 percent of state-generated revenue—and spending to fully fund OPEB obligations would have outpaced what states contributed to active state employee health premiums.
- The states that automatically increased their retiree health insurance premium contribution when the total cost of the premium rose had higher OPEB liabilities relative to the size of their economies in 2013, while

the states that paid a fixed amount toward retirees' health insurance premiums had relatively lower OPEB liabilities.

- States varied in how they modified retiree health plan provisions. For example, between 2000 and 2015, Idaho eliminated retiree health coverage for newly hired employees; at least five states stopped making any health premium contribution for certain retirees; and over a dozen states changed the minimum age or the number of state service years required for retirees to be eligible for health benefits.
- 35 states have implemented Medicare Advantage or Employer Group Waiver Plans to provide health or prescription drug benefit coverage for Medicare-eligible retirees since these options were authorized as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[8] These cost-saving programs provide states with financial subsidies from the federal Medicare program to provide Medicare plus wraparound benefits.[9] (See "Glossary" box.)

As state policymakers address challenges in providing retiree health care, this report is intended to help them better understand how their spending, long-term liabilities, and criteria for premium contributions and coverage eligibility compare with those of other states.

The State Health Care Spending 50-State Report Series

The State Health Care Spending Project, a collaboration between The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, is examining seven key areas of state health care spending—Medicaid, the Children's Health Insurance Program, substance use disorder treatment, mental health services, prison health care, active state government employee benefits, and retired state government employee benefits. The project provides a comprehensive examination of each of these health programs that states fund. The programs vary by state in many ways, so the research highlights those variations and some of the key factors driving them. The project concurrently released state-by-state data on 20 key health indicators to complement the programmatic spending analysis. For more information, see pewtrusts.org/healthcarespending.

Glossary

Annual required contribution. The ARC is an accounting metric and disclosure requirement defined by the Governmental Accounting Standards Board and calculated by each state's actuary. Using the economic and demographic assumptions of the plans, the ARC calculation includes the expected cost of benefits earned for the current year and an amount to reduce some of the unfunded liability, called an amortization payment. The amortization payment is calculated based on the number of years—or amortization period—assumed to fully pay for the unfunded liability.[10]

While most states pay only for current benefit costs each year, some of the states that pre-fund their other post-employment benefits (OPEB) liabilities include amortization payments based on ARC calculations.

Dependent. For this analysis, our definition of dependent includes survivors, spouses, dependent children, and other retiree dependents as defined by individual states.

Discount rate. The discount rate is the assumed interest rate used to account for the fact that money invested now will accumulate interest and be worth more later.[11]

Employer Group Waiver Plan. An EGWP is an option employers have, through the Medicare program, to provide prescription drug coverage to retirees who would otherwise enroll in a commercial Medicare Part D prescription drug plan.[12] Most states offering an EGWP contract with an insurer to provide prescription drug coverage to their retirees.[13] The insurance provider contracts directly with Medicare and receives risk-adjusted capitated payments.[14] Alternatively, a state can offer prescription drug coverage through a self-run (or self-insured) plan and receive risk-adjusted capitated payments directly from Medicare.[15]

Other post-employment benefits. In addition to pension benefits, state governments offer other post-employment benefits. Expenditures for these benefits consist primarily of retiree health insurance expenses, but may also include a small percentage of expenditures for other insurance coverage such as dental, vision, life, or disability.[16] This analysis focuses on state government OPEB expenditures; however, our source for OPEB financial data may include data on OPEB for local retirees or teachers in localities where those plans are administered by the state and the state maintains a financial interest in them. (See Appendix A: Methodology.)

OPEB liabilities. OPEB liabilities reflect the expected cost of these benefits for current workers and retirees over the course of their lives. These liabilities are self-reported and calculated by each state's actuary according to the standards set forth by the GASB.[17]

Retiree Drug Subsidy Plan. An RDS Plan is a traditional prescription drug insurance plan that states can offer retirees who might otherwise enroll in a Medicare Part D prescription drug

Continued on the next page

plan.[18] As part of the RDS program, states may receive reimbursement of up to 28 percent for allowable prescription claims for RDS Plan enrollees, within a certain dollar threshold.[19] The RDS program was created when Medicare Part D was enacted to encourage employers to continue offering traditional drug coverage to their Medicare-eligible retirees.[20]

State-generated revenue. State-generated revenue is money that states raise on their own, primarily through taxes and fees, and does not include any federal revenue, such as matching dollars or grants.[21]

Wraparound coverage. For the purposes of this analysis, wraparound coverage includes coverage that is secondary to Medicare Parts A and B and may cover Medicare copays, coinsurance, and deductibles. Wraparound coverage may also cover services not covered by Medicare and may reimburse providers for costs above Medicare reimbursement. States may also choose to offer a Medicare Advantage plan, which is partially paid for by the federal government. This coverage option allows states to coordinate with the federal Medicare program to offer comprehensive benefits to Medicare-eligible retirees.[22]

State OPEB liabilities

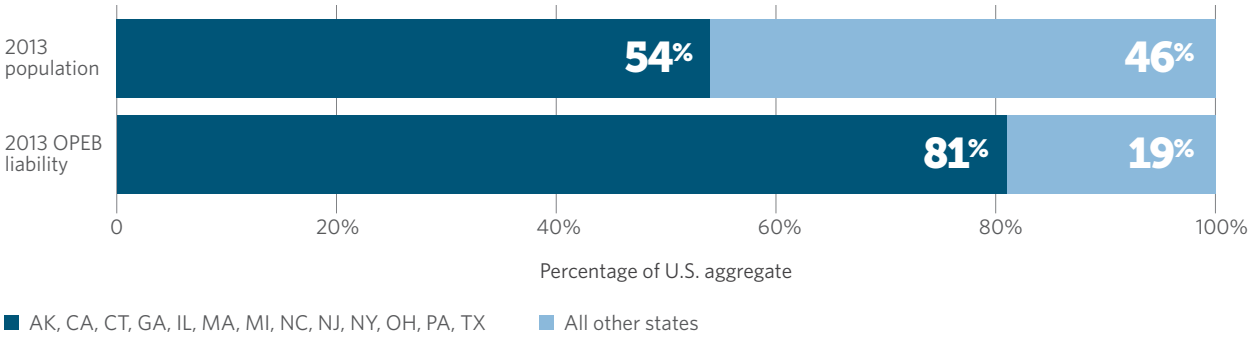
In 2013, states reported a combined $627 billion liability for OPEB, representing the expected cost in today's dollars of benefits to be paid to current workers and retirees over their lifetimes.[23]

Much of this liability is concentrated in 13 states. (See Figure 1.) Although these states represented about half of the U.S. population in 2013, they accounted for 81 percent of the total OPEB liabilities for all 50 states.

Figure 1

OPEB Liabilities Are Concentrated Among Several States

13 states represent 81% of total, 2013



Source: Analysis of data from states' Comprehensive Annual Financial Reports, the U.S. census, actuarial reports and valuations, other public documents, or from plan officials

OPEB liability funded ratios

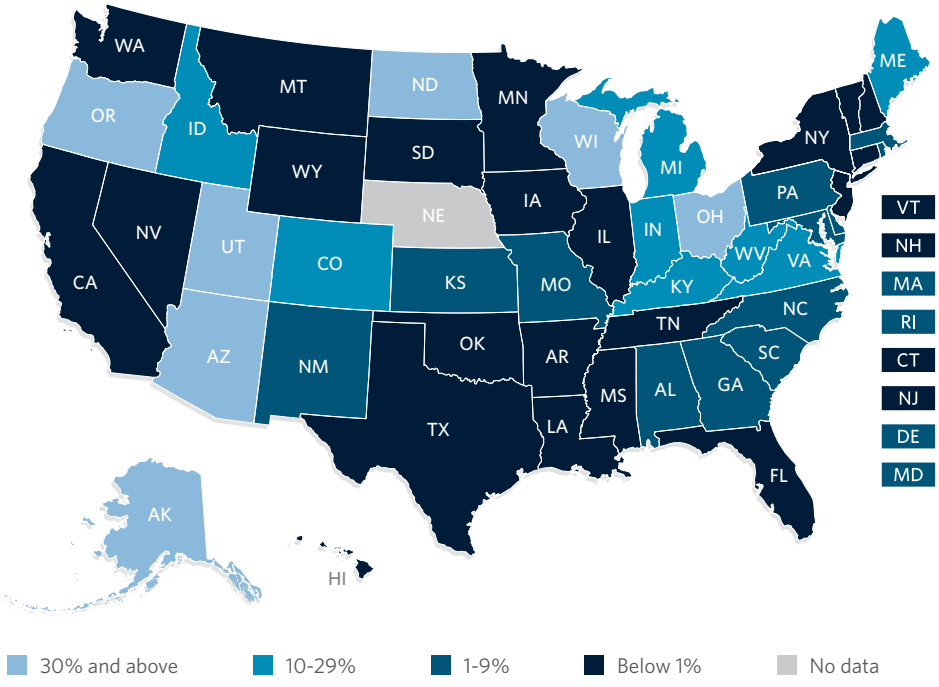
One strategy states use to manage OPEB liabilities is to set aside assets to pre-fund these costs and leverage the compounded returns these assets may be projected to accrue.[24] A state's funded ratio measures the assets the state has set aside as a percentage of its OPEB liability.[25] Pre-funding requires additional resources from the budget in the near-term but can lower long-term costs by generating earnings on the invested assets.[26] Most states, however, pay for benefits on a pay-as-you-go basis instead, with no pre-funding.[27] In fiscal year 2013, states had only $40 billion in assets—or approximately 6 percent of the $627 billion total—saved to cover the costs associated with their OPEB liabilities. State-funded ratios varied greatly, ranging from less than 1 percent in 22 states to 73 percent in Arizona.

Figure 2 shows that only seven states have an OPEB funded ratio of 30 percent or greater: Alaska, Arizona, North Dakota, Ohio, Oregon, Utah, and Wisconsin. These states typically follow explicit pre-funding policies that are written into state law. Ohio and Arizona, for example, employ 30- and 15-year amortization periods, respectively, to pay down unfunded liabilities over time. (See "Glossary" box definition of annual required contribution for more information on amortization periods.)[28] Both states also leverage the expertise of their state's pension system to invest and manage plan assets; the Ohio Public Employees Retirement System and the Arizona State Retirement System are responsible for day-to-day administration of OPEB and also investing plan assets.[29]

Figure 2

Most States Pre-Fund Less Than 10% of OPEB Liabilities

State-funded ratios, 2013



Note: Nebraska does not report an OPEB liability.

Source: Analysis of data from states' Comprehensive Annual Financial Reports, actuarial reports and valuations, other public documents, or from plan officials

Changes to liabilities over time

In aggregate, states' reported OPEB liabilities declined by 10 percent between 2010 and 2013, to $627 billion, adjusting for inflation. (See Appendix B.) However, individual state trends varied significantly; 39 states decreased their liability, and 10 states increased theirs, adjusting for inflation.[30] A wide variety of factors affect whether states' OPEB liabilities increase or decrease, including health care inflation, changes to retiree health plan design and eligibility criteria, and changes to actuarial assumptions.

> In 2013, 13 states accounted for 81 percent of the nation's total OPEB liabilities.

- **Change in health care cost trend.** Owing to lower-than-expected rates of growth in health care spending—annual rates were about 5 percentage points lower than expected between 2010 and 2013—actuaries reported lower levels of health care spending in their 2013 OPEB valuations.[31] For example, California, Georgia, and Massachusetts—representing over $115 billion in state OPEB liabilities in 2013—cite lower-than-expected health care claims costs in recent valuation reports as a reason that reported OPEB liabilities were either reduced or grew less than the rate of inflation.[32] As a result, realized costs—which serve as the base for projecting future costs and, in turn, reported liabilities—have been lower than expected.[33]
- **Impact of changes to retiree health plan eligibility and state premium contribution policies.** Several states that experienced lower OPEB liabilities adopted changes to criteria for eligibility and premium contributions related to retiree health plan coverage. All other factors being equal, when these changes apply to current workers and retirees, they have a greater effect on OPEB liabilities than does a change affecting only newly hired workers. Further, in 2011, West Virginia capped the growth of its contribution to health premiums for eligible retirees by 3 percent annually, shielding itself from the full effect of annual retiree health premium increases and lowering its liabilities by $2.6 billion.[34] In states where retiree health plan eligibility changes apply primarily to newly hired workers, the impact of these changes is less significant because fewer individuals are affected by them.

> In aggregate, states' reported OPEB liabilities declined by 10 percent between 2010 and 2013, to $627 billion, adjusting for inflation.

- **Impact of changes to retiree health plan design.** Liabilities were also reduced in some states as a result of changes to the structure of states' Medicare-eligible retiree prescription drug benefits. Several states transitioned to providing prescription drug benefits to Medicare-eligible retirees through a cost-saving Employer Group Waiver Plan (EGWP) and saw reductions in their OPEB liabilities. (See the "Glossary" box.) In addition to cost savings, states that provide benefits through this structure also enjoy more favorable accounting treatment when calculating OPEB liabilities.[35] Louisiana and New Jersey saw OPEB liability reductions of $2 billion and $11 billion, respectively, after adopting an EGWP in 2012.[36] Connecticut also adopted an EGWP in addition to amending eligibility requirements in 2011, which reduced its OPEB liability by $4.9 billion.[37]

The Medicare Program

Medicare is a federal health insurance program for individuals 65 or older, as well as younger adults with disabilities and/or end-stage kidney disease.[38] The Medicare program includes four distinct types of health insurance coverage:

- **Medicare Part A** covers inpatient hospital stays, nursing home care, hospice care, and some home health care.[39] If a retiree paid into the Medicare program while he or she worked, the individual is eligible for this benefit premium-free.[40]
- **Medicare Part B**, an optional benefit, covers preventive care, approved outpatient care services, and medical supplies.[41] Beneficiaries pay a monthly premium on a sliding scale based on income, commonly through a deduction from their Social Security benefit check.[42]
- **Medicare Part C (Medicare Advantage)** is a managed care plan option that combines Part A, Part B, and sometimes Part D benefits.[43] Participants choose plans offered by commercial insurers, which are required to cover the same benefits as Parts A and B at a minimum but may also include lower cost-sharing responsibilities and/or Part D prescription drug benefits.[44]
- **Medicare Part D**, typically provided through a commercial insurance plan, is an optional benefit for prescription drug coverage; it commonly requires recipients to pay an additional monthly premium.[45]

In addition to the Medicare benefits described above, many retirees also purchase Medicare supplemental insurance, or Medigap, to pay for services not covered by Medicare Parts A and B, as well as all or a portion of Medicare's coinsurance and deductibles.[46]

- **Changes to actuarial assumptions.** Even small changes to actuarial assumptions can have a significant impact on reported liabilities. Many actuarial assumptions are based on historical data; however, assumed rates of return on invested assets, or discount rates, are primarily based on whether the state sets aside assets to pre-fund its OPEB liabilities.[47] (See "Glossary" box.) Because pre-funding can lower long-term costs by generating investment returns on the money set aside, states that pre-fund can use a higher discount rate than states that do not. As a result, those that adopt pre-funding policies can expect decreases in OPEB liabilities.[48] For instance, Michigan began pre-funding and raised its discount rate for large plans by 4 percentage points in 2012, which contributed to the drop in its reported liabilities by nearly half from 2010 to 2013, adjusting for inflation.[49] West Virginia also saw its total OPEB liability drop 58 percent from 2010 to 2013, adjusting for inflation. The state made changes to its policies on health plan premium contributions and raised its assumed discount rate from 3.6 percent to 6.1 percent in connection with a decision to pre-fund.[50]

In addition to assumed discount rates, other factors, including demographic assumptions, will affect reported OPEB liabilities moving forward. Accounting for these shifts could increase OPEB liabilities if actuaries assume benefits will be paid out over a longer period, although this may be offset by increasingly deferred retirement ages, which also result from increased life spans.

GASB Updates on OPEB Accounting Standards

Starting with fiscal years beginning after June 15, 2016, the Governmental Accounting Standards Board will implement new and expanded requirements for reporting on the financial standing of states' programs on other post-employment benefits (OPEB).[51] The updated standards will make comparative analysis of OPEB plans more feasible and increase transparency around state OPEB liabilities as well as public officials' understanding of OPEB plans' financial health.[52] These requirements will include:

- **Greater uniformity in actuarial assumptions.** By requiring actuaries to use specific actuarial methodologies when projecting costs and calculating liabilities, the new standards will increase the ability to compare financial statements across states.[53] For instance, all states will be required to use a standard method of calculating the present value of benefits.[54] Many states presently use a variety of methods, resulting in difficulties comparing states' liabilities and funded ratios.[55] The discount rate, one of the most important economic assumptions used in the valuation, will now be determined by reference to a specific methodology, improving comparability.[56]
- **New disclosures on OPEB investment trust practices and governance.** States will be required to report descriptive information on OPEB plan governance (including the composition of the boards overseeing OPEB plans), the types of state retirees covered by each OPEB plan, and the benefits each plan provides.[57] States will also be required to disclose OPEB plan investments, their rate of return, and the state policies governing those investments.[58]
- **Additional financial statements.** GASB will require state governments to publish additional financial statements in the state Comprehensive Annual Financial Report to provide stakeholders with more comprehensive OPEB plan data.[59] These will include detailed OPEB financial data and investment gains and losses for the 10 most recent fiscal years, allowing stakeholders to have longitudinal data in one place to better study trends.[60]

As more states move to pre-fund their unfunded OPEB liabilities (the cost of benefits promised to current and future retirees that are not covered by existing assets), this additional information will assist the public in evaluating plan governance and the effectiveness of a plan's investment strategy.

> In 2013, states spent approximately $18.4 billion funding their OPEB programs ... less than 2 percent of state-generated revenue.

Annual state OPEB spending

Most states' current spending on OPEB programs is a relatively small proportion of the total revenue they have available from their own sources. However, if they contributed the full actuarially determined amount to a trust fund, it would be more than double their current cash payments and would exceed spending on active state employee health premiums. States must weigh current budget demands against the pressure to reduce unfunded OPEB liabilities by considering pre-funding them.

Annual state expenditures

In 2013, states spent approximately $18.4 billion funding their OPEB programs. This amount was less than 2 percent of state-generated revenue, slightly lower than active state employee premium spending, and much lower than Medicaid, the state's largest health care expenditure. Individual state spending on OPEB as a percentage of own-source revenue varied widely, from 6 percent in Alaska to less than 1 percent in 25 states.

These numbers reflect states' actual expenditures for OPEB, which represent how much states paid that year for health insurance and other benefits for current retirees and can also include spending to pre-fund liabilities for these benefits. For states that pay the cost of retiree benefits each year without pre-funding, actual OPEB expenditures are a close approximation of annual spending on retiree health insurance and other benefits.[61] For states that set aside assets toward funding the promises they've made to retirees, actual OPEB expenditures are greater than annual costs because these expenditures include funding for future years.[62] (See Figure 2.)

Annual required contributions

In addition to reporting OPEB assets, liabilities, and actual expenditures, states must also report the annual required contribution.[63] (See "Glossary" box.) The ARC consists of the cost of benefits earned in the current year plus an additional amount to fully fund the state's OPEB liability over time.[64] The ARC is an accounting metric and disclosure requirement defined by the GASB and calculated by each state's actuary.[65] States that pay the ARC can cut long-term costs substantially because the interest they are likely to earn when investing more money over the long term can be applied to offset their liabilities.[66]

In 2013, the national aggregate ARC was $48 billion; actual state expenditures added up to only 39 percent of the ARC. (See Appendix C.) Only three states contributed their entire ARC in 2013: Arizona, Rhode Island, and Utah. When these states contribute their ARC, GASB accounting standards allow them the advantage of assuming a higher return on their invested funds when calculating OPEB liabilities, thereby significantly decreasing these liabilities.[67] States that do not pre-fund their OPEB liabilities are required to assume a lower return on investment when reporting OPEB liabilities. States that demonstrate a commitment to pre-funding by gradually ramping up their ARC payments are also allowed to use a higher "blended" assumed rate of return.[68]

If the remaining states had set aside funding to pay for these long-term benefits based on ARC calculations, their total payments in 2013 would have represented 4 percent of their state-generated revenue—more than double their actual expenditures. Although the national aggregate ARC payment represents a relatively low percentage of state-generated revenue, it varies significantly by state. The ARC payments for Hawaii and New Jersey represented more than 10 percent of each of these states' own-source revenue in 2013.

Provisions of state retiree health insurance plans

Although actuarial methods and assumptions are critical to understanding state spending and liabilities for retiree health care, the design of retiree health benefits is also important. States have wide latitude in deciding what benefits to offer (or even whether to offer health coverage to retirees), who is eligible, and how the retiree and the state should share the cost of the premium.[69] States must decide these policies for two distinct types of retirees: Medicare-eligible retirees and retirees who are not yet eligible for Medicare, or "early retirees" for the purposes of this report.

States periodically modify their policies over time and decide whether these changes apply to current retirees and/or future retirees (i.e., current state workers). In practical terms this means, for example, that we say 48 states (Indiana and Nebraska excluded) provide health insurance coverage or access to coverage to their Medicare-eligible retirees but only 47 states (Idaho, Indiana, and Nebraska excluded) offer retiree coverage to a public worker hired today who will retire sometime in the future. In the section that follows (including Figures 3 and 4) we report on the benefits for recent retirees, as an indicator of current costs and reported liabilities. Following Figure 4 we report on benefit data that pertains to retirement benefit provisions offered to public workers hired today and retiring sometime in the future.

Cost of Early Retiree vs. Medicare-Eligible Retiree Coverage

Although early retirees are likely to be in better health and therefore less expensive to insure than older Medicare-eligible retirees, states pay a higher per-person cost for early retirees than they do for Medicare-eligible retirees.[70] This is because federal Medicare covers a large portion of the cost to cover Medicare-eligible retirees.[71]

These choices are not made in a vacuum. They are affected by fiscal and political pressures and often subject to collective bargaining between states and state employee unions.[72] States also use retiree health benefits in an effort to help attract and retain talented workers, an additional factor that states consider when weighing costs against the design of benefits.[73] Because of these factors and others, state policies change over time. For instance, 35 states have taken advantage of changes to the federal Medicare program that allow them to continue providing supplemental Medicare coverage to eligible retirees at a lower cost. States' retiree health insurance programs will continue to evolve as states face new challenges and opportunities.[74]

State contributions to premiums for retiree health insurance plans

Our analysis shows that 39 states contribute a portion of the premium for early retirees' comprehensive health insurance, and the same number—although not necessarily all the same states—provide a portion of the premium for wraparound coverage for Medicare-eligible retirees. Both are significant because comprehensive coverage is more expensive than wraparound coverage.[75] However, there are more Medicare-eligible retirees, and these older retirees are likely to have more health care needs than do early retirees. (See "Early Retirees and the Affordable Care Act" box.) The amount of each state's premium contribution and the criteria that each state uses to determine that contribution vary. Regardless of how the subsidy is calculated, retirees make up the difference between the state's contribution and the total premium, in addition to paying for any out-of-pocket costs such as deductibles or copays.[76]

Early Retirees and the Affordable Care Act

Before the Patient Protection and Affordable Care Act (ACA), employer-sponsored health insurance coverage for early retirees was particularly valuable. Such retirees who were no longer eligible for health coverage through their former employer, not eligible for coverage through their spouse, and not yet eligible for Medicare had to purchase coverage on the individual health insurance market if they wanted to be covered.[77] However, because retirees of any age are more likely than active employees to have chronic health conditions, they could be denied coverage due to pre-existing conditions before implementation of the ACA's "guaranteed issue" provision (which prohibits health insurance companies from denying coverage due to an applicant's pre-existing condition).[78] This was not an issue with employer-sponsored early retiree health insurance, however, as it has always been guaranteed issue.[79]

State retiree health insurance coverage—even in the absence of a state contribution to the premium—is valuable to early retirees in several ways. First, premiums are lower than they are on the individual market, a result of participation in a large group insurance pool that has considerable negotiating power with insurers.[80] Second, early retirees with access to the same health insurance and total premium offered to their states' active employees also benefit from an implicit subsidy.[81] Based on historical data and trends, these early retirees have higher health care costs, on average, than active employees.[82] However, states that offer the same premium to early retirees and active employees create a "blended" premium, with active employees paying a higher premium and early retirees a lower one than they would otherwise.[83]

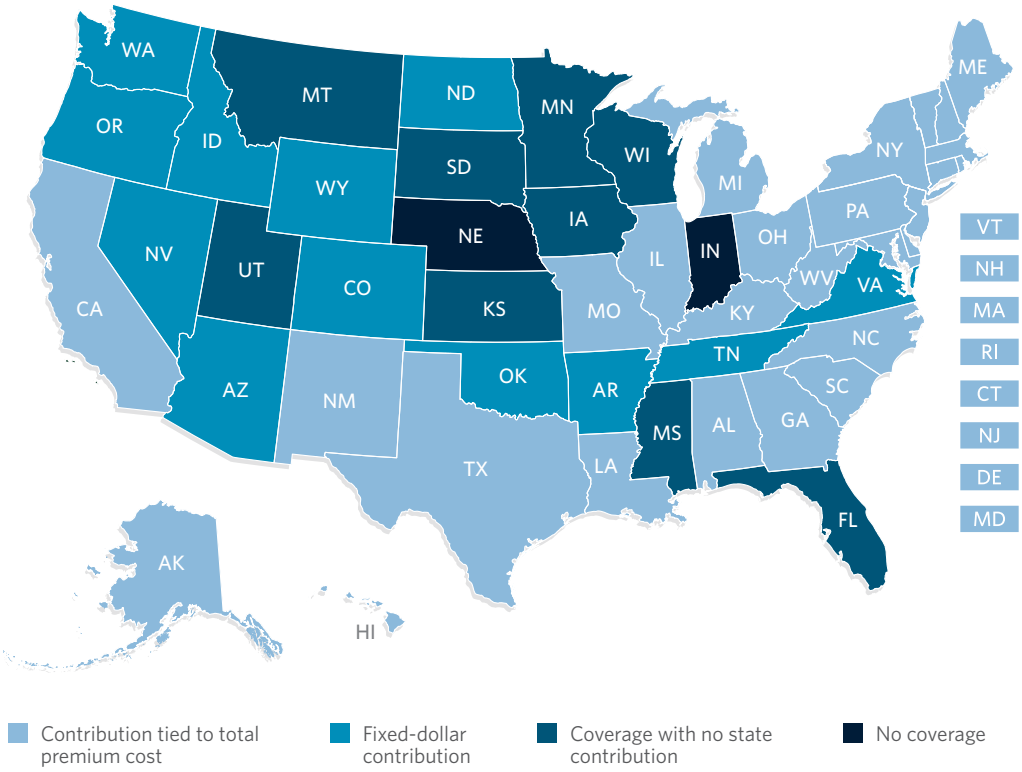
Premium contribution method. States use various methods to determine how much they contribute to premiums for early and Medicare-eligible retiree health insurance. (See Figure 3.) For the purposes of this analysis, we list and discuss state contribution methods only for Medicare-eligible retirees, although most states use the same premium contribution method for both categories.[84]

- **Fixed-dollar contributions.** Twelve states offer a fixed-dollar contribution toward retirees' health premiums. Retirees pay the difference between the fixed subsidy and actual premiums for their benefits. Because they are shielded from health plan premium increases, states that structure contribution options in this manner have somewhat more predictable retiree health insurance costs from year to year.
- **Contribution tied to health insurance premium.** Twenty-seven states tie their retiree premium contribution to the cost of health insurance, and therefore have less control over how much their contribution rises each year. States pay either a percentage of the premium for the plan selected or a fixed price set to change when health insurance premiums change. If premium costs increase, states using this contribution method must increase their spending, decrease their contribution, or introduce lower-cost plans.
- **Coverage with no state contribution.** Nine states do not make a contribution toward premiums for their retirees.[85]

Figure 3

Most States Tie Contributions to Premiums' Total Cost

State premium contribution method for Medicare-eligible retirees



Notes: Nevada provides its Medicare-eligible retirees access to health coverage through a private exchange.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states

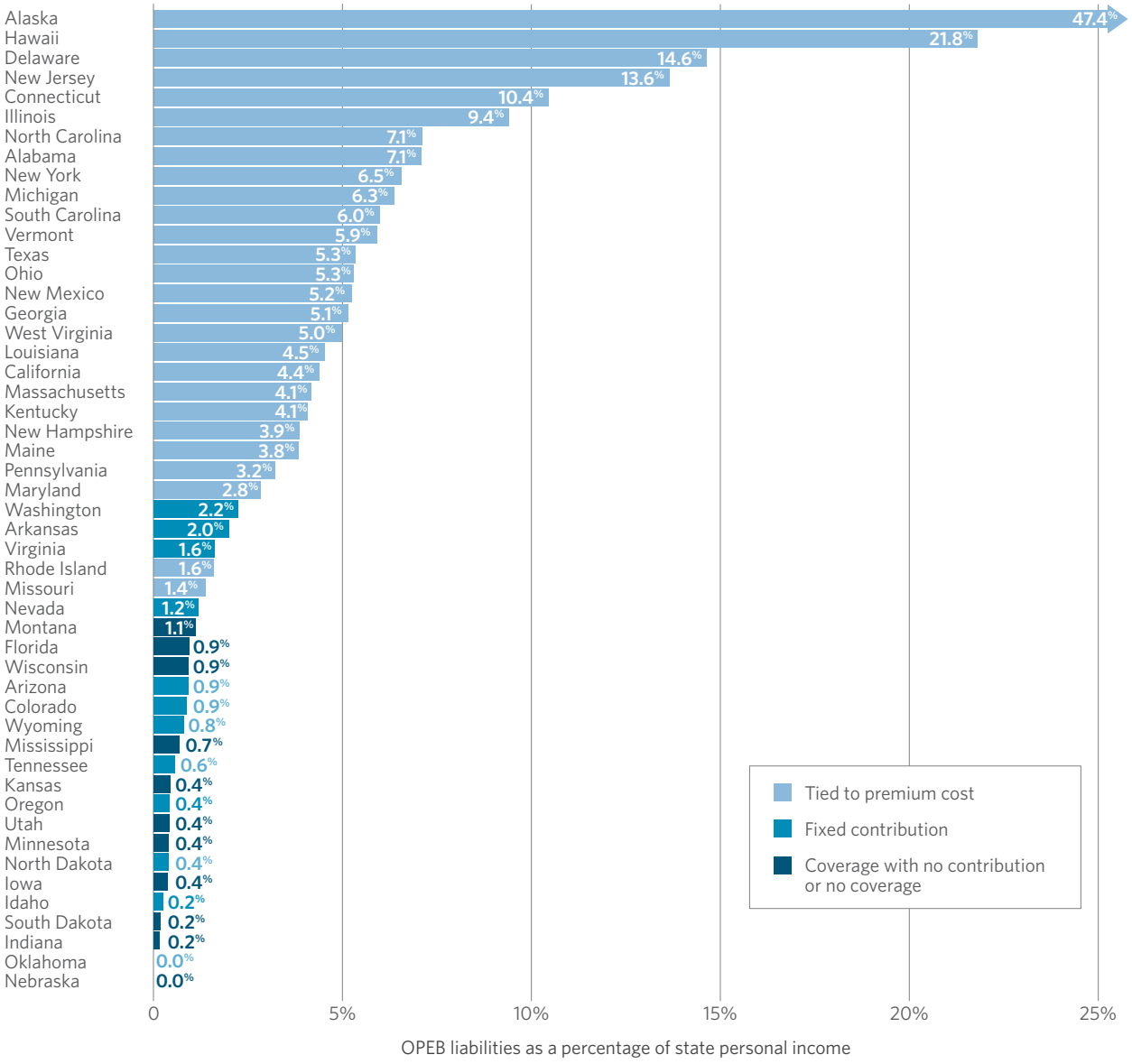
Premium contribution method and OPEB liabilities. The methods states use to calculate their contributions to retiree health insurance premiums affect their OPEB liabilities in addition to other factors, such as whether the state also manages local government retiree health care benefits.[86] (See Appendix A: Methodology.) Project researchers compared states' 2013 OPEB liabilities to 2013 state personal income, a ratio that shows these liabilities in relation to the potential resources states have on hand to pay for these costs.[87] Figure 4 shows that states that tied their premium contribution to the cost of health care generally had the highest OPEB liabilities as a percentage of state personal income.

States that provide a fixed-dollar premium contribution are clustered around the middle of the range of liabilities. Setting a fixed-dollar premium contribution helps states manage their share of retiree health premium costs by keeping their contribution stable. States that provided no premium contribution to retirees in 2013 tended to have the lowest liabilities as a percentage of state personal income. Although these states do not subsidize coverage, they may have liabilities from the costs of administering the health plans, offering nonhealth OPEB benefits (such as life insurance or disability insurance), continuing benefits for "grandfathered" retirees who may still be eligible for premium contributions, or implicitly subsidizing early retiree health premiums. (See "Early Retirees and the Affordable Care Act" box.)

Figure 4

State Premium Contribution Methods for Medicare-Eligible Retirees Drive OPEB Liabilities

2013 OPEB liabilities as a percentage of state personal income by premium contribution method



Notes: Consistent with Figure 3, data reflects the benefits for recent retirees as an indicator of current costs and reported liabilities. As of February 2015, five states have made changes to their contribution method for new hires when they become Medicare-eligible retirees: Idaho provides no coverage, Kentucky provides a fixed-dollar contribution, and Nevada, Oregon, and West Virginia provide coverage but no contribution. Nebraska does not report an OPEB liability. Nevada provides access to coverage for its Medicare-eligible retirees through a private exchange.

Source: Analysis of data from states' Comprehensive Annual Financial Reports and publicly available information on retiree health benefit plans verified by states (see Appendix A), U.S. Census data, actuarial reports and valuations, other public documents, or from plan officials

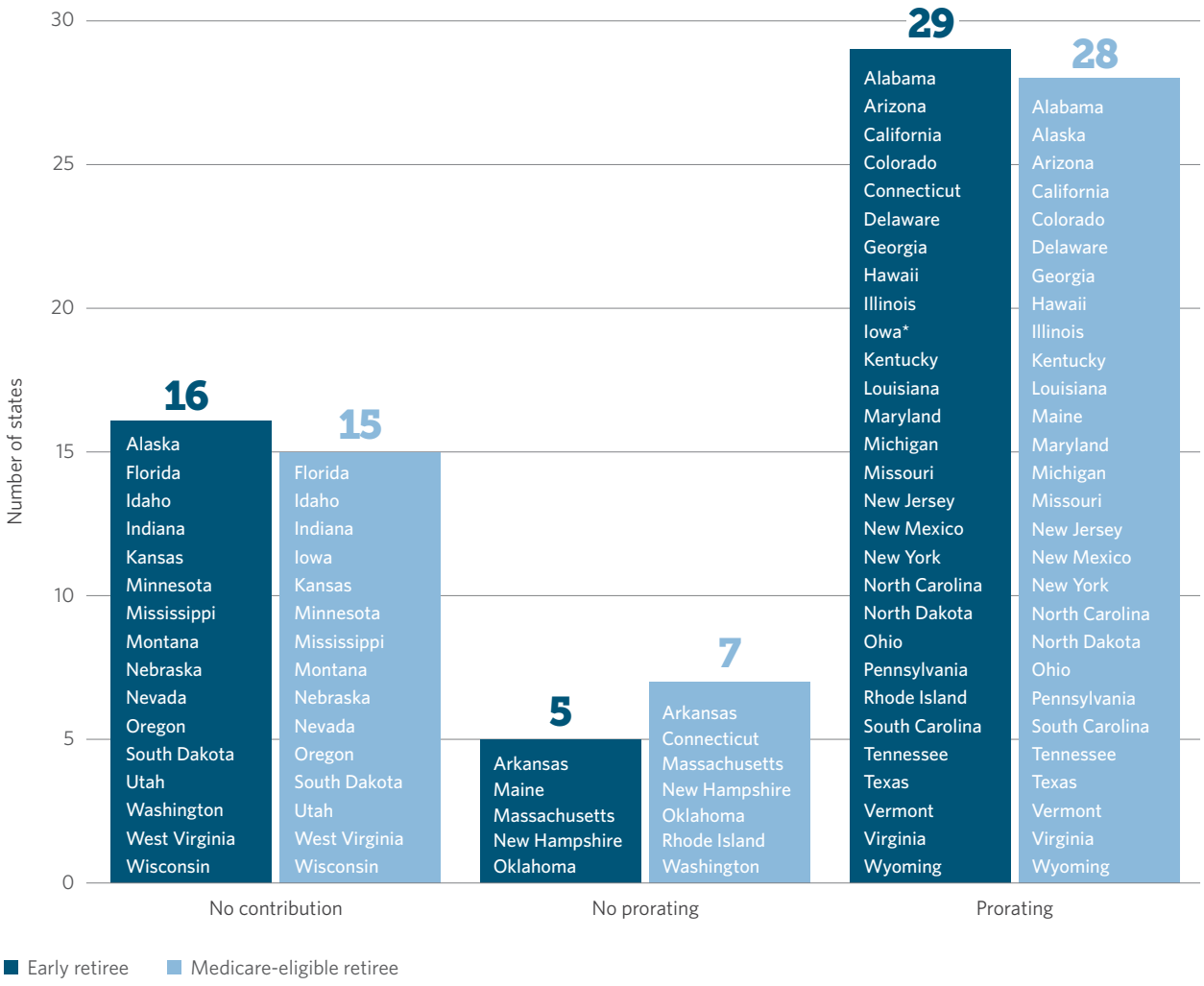
Retirement benefit provisions may differ for workers hired today

The previous analyses looked at benefits for recent retirees as the main driver of current costs. But in light of unfunded OPEB obligations and budget challenges, state policymakers periodically change benefit provisions. The following sections look at the retirement benefit provisions for a public worker hired today. In some instances these benefit provisions have been in place for years, in others they represent recent policy changes. See Appendix D for more data on retiree health benefit provisions for state employees.

Figure 5

Most States Prorate Their Contributions to Retiree Premiums

Prorating policies for these contributions



* Iowa provides a credit for unused sick leave.

Note: This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

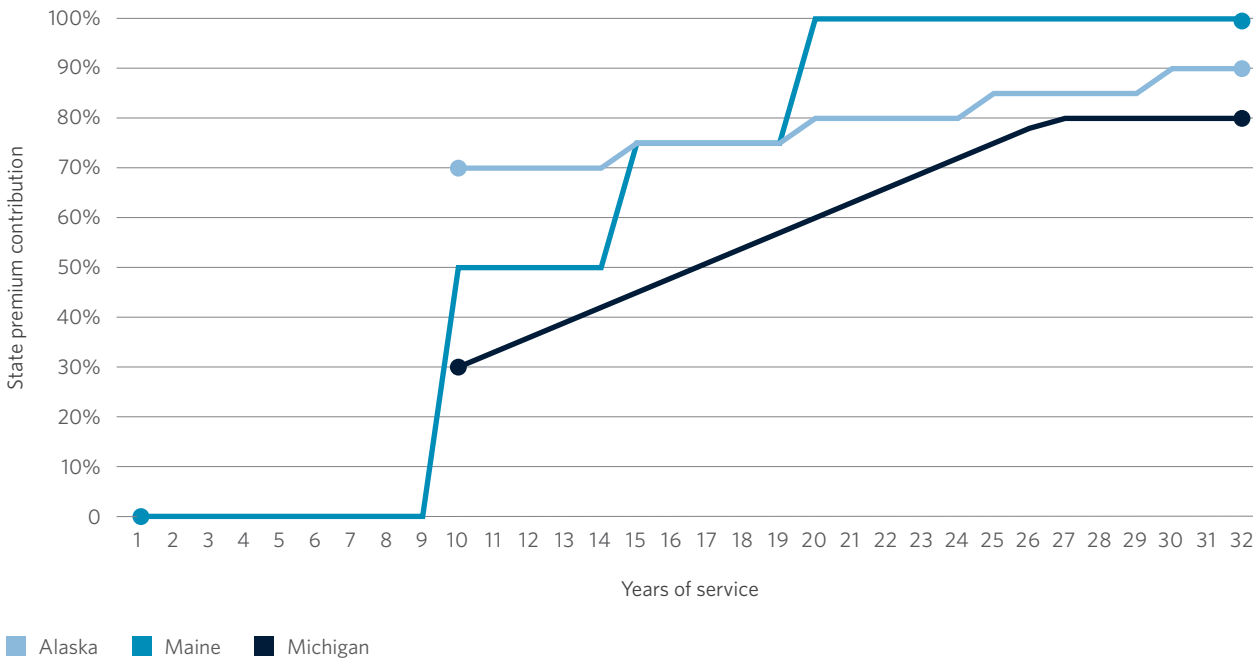
Prorating state premium contributions. Thirty-one states have adopted policies to prorate their premium contributions to early or Medicare-eligible retirees based on a formula that takes into account retirees' years of service (YOS), age, or other factors.[88] Prorating provides incentives to state retirees to retire later or select less comprehensive health plans, often decreasing costs to the state and potentially to the retiree.[89] It also aligns the value of this significant benefit and the contribution the participant made to the sponsoring agency while employed there. Figure 5 shows which states provide a premium contribution for their early and Medicare-eligible retirees and which prorate those contributions. Most states that use prorating apply it to both early and Medicare-eligible retirees.

Figure 6 shows how prorating formulas vary for Medicare-eligible retirees in three states that use a retiree's years of service to calculate the percentage of premium the state will contribute. States such as Alaska use a tiered approach to prorating. Once Alaska state retirees reach 10 years of service, they are eligible for a 70 percent premium contribution. The contribution increases 5 percentage points for each additional five years, maxing out at a 90 percent contribution with 30 years of service. Maine also uses this tiered approach, but after 10 years of service it increases its contribution by 25 percentage points for every five years, up to a 100 percent premium contribution. In addition, a Maine state employee qualifies for coverage—albeit with no state premium contribution—in his or her first year of service, which is not the case with an Alaska state employee. Michigan increases its premium contributions by 3 percentage points with each year of service until maxing out at 27 years.

Figure 6

State Premium Prorating Formulas Vary Significantly

Selected examples for Medicare-eligible retirees



Note: This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Eligibility criteria

States set minimum eligibility criteria for retiree health plan coverage based on age and years of service. For about half of the states, minimum age and years of service eligibility criteria were tied to retiree pension eligibility. The remaining states set their health and pension benefit eligibility criteria separately or did not report data.

Age eligibility requirements. Twenty states set minimum eligibility ages for early retirees ranging from 50 to 62. For these states, the median age for benefit eligibility is 55. In contrast, 29 states do not set a specific minimum age for eligibility. For example, Texas applies the "Rule of 80," meaning that employees may retire at any time so long as their age and years of service add up to 80. Similarly, while Georgia does not have a minimum age requirement, employees must have worked for the state at least 10 years to be eligible for benefits.

Minimum years of service requirements. States usually require retirees to work for the state for a minimum number of years before they are eligible for health care coverage, whether such coverage is state-subsidized or not. Of the 49 states offering coverage to early retirees, 46 have years of service requirements for coverage eligibility.[90] Forty-seven states offer coverage or access to coverage to Medicare-eligible retirees, and 39 of these have minimum years of service requirements for such coverage eligibility.[91]

States also set minimum years of service requirements that retirees must meet to receive a state premium contribution. For the states that offer a premium contribution, the median number of years of service required for premium contribution eligibility is 10 years for both early and Medicare-eligible retirees. (See Figure 7.) Although most states have the same minimum eligibility criteria for both early and Medicare-eligible retirees, Alaska, Colorado, Iowa, North Dakota, and Washington do not.

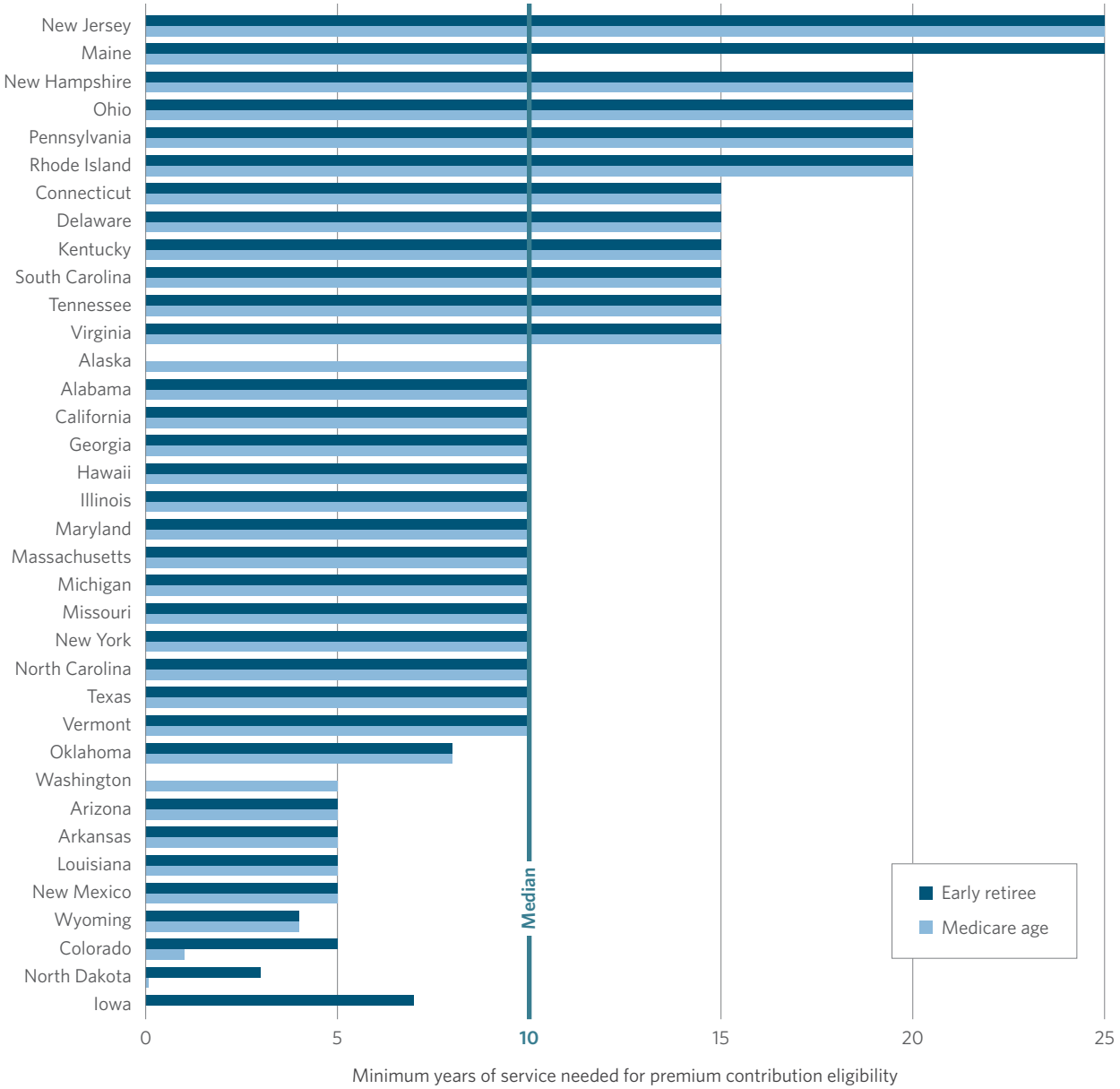
- **Early retirees.** Thirty-four states contribute to early retirees' health insurance premiums with minimum years of service requirements. This requirement ranges from three years in North Dakota to 25 years in Maine and New Jersey. The remaining 15 states do not offer premium contributions for their early retirees. (Idaho does not offer coverage to its early retirees hired after June 30, 2009.)
- **Medicare-eligible retirees.** Thirty-five states contribute to their Medicare-eligible retirees' health insurance premiums after these retirees meet minimum years of service requirements, ranging from one month in North Dakota to 25 years in New Jersey. The remaining 12 states do not offer a premium contribution for Medicare-eligible retirees (Idaho, Indiana, and Nebraska do not offer coverage for their Medicare-eligible retirees).

Dependent coverage. Many states offer health insurance to retirees' dependents and survivors, increasing the number of individuals the state covers and raising state costs. (See Figure 8.) These costs increase when the state contributes toward dependent health insurance premiums. (See "Glossary" box.) Forty-eight states offer health insurance coverage or access to coverage to early retirees' dependents, and 46 states offer such coverage to Medicare-eligible retirees' dependents.[92] Among these states, 25 provide a premium contribution to early retirees' dependents, and the same number—although not necessarily all the same states—provide a premium contribution to Medicare-eligible retirees' dependents. The remaining states do not contribute toward dependent premiums.

Figure 7

States Require a Median of 10 Years of Service for Premium Contribution Eligibility

Minimum years of service required



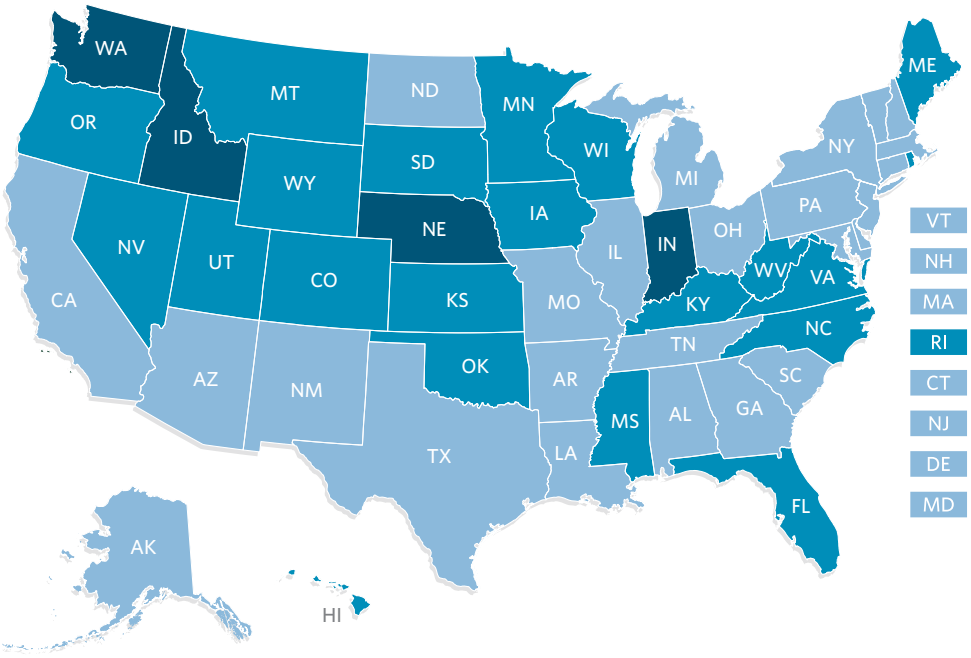
Note: Florida, Idaho, Indiana, Kansas, Minnesota, Mississippi, Montana, Nebraska, Nevada, Oregon, South Dakota, Utah, West Virginia, and Wisconsin either provide coverage but do not make contributions toward retiree health care premiums or do not provide coverage to either their early or Medicare-eligible retirees. This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Figure 8

Most States Offer Coverage, Premium Contributions for Retirees' Dependents

Coverage of Medicare-eligible retiree dependents



Note: Dependents of early retirees in Alaska, Indiana, and Nebraska are eligible for coverage with no premium contribution. In Iowa, such dependents are eligible for coverage with a premium contribution. Nevada offers access to coverage for Medicare-eligible dependents through a private exchange. This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Health and prescription coverage type for Medicare-eligible retirees

States have different health plan coverage structures for Medicare-eligible retirees depending on how they choose to coordinate their benefits with the federal Medicare program, which can affect their costs. In addition to the contribution some states make to the cost of state-sponsored coverage, several states also make a contribution toward Medicare-eligible retirees' Medicare Part B premiums.

Coverage of health benefits. The 47 states providing health coverage or access to coverage to Medicare-eligible retirees offered Medicare wraparound health plans to Parts A and B, Medicare Advantage (Part C), or both.[93] (See Figure 9 and "The Medicare Program" box.)

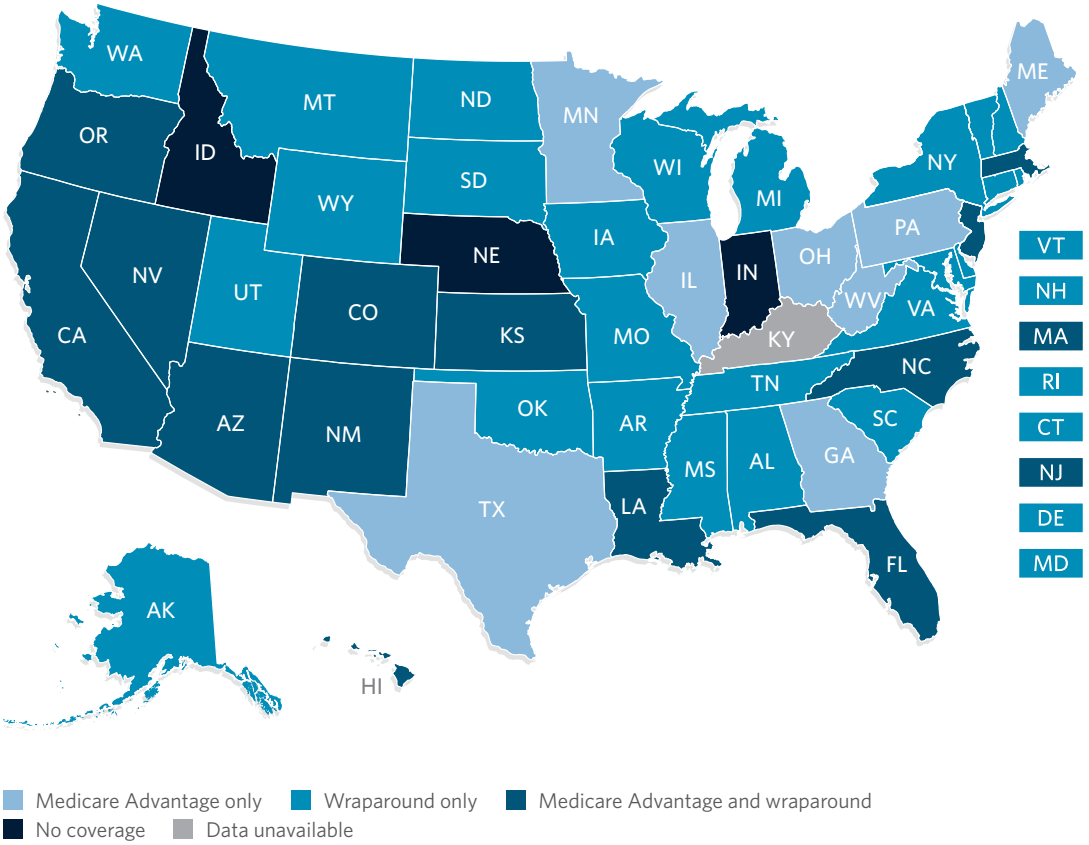
- **Medicare wraparound plans.** Thirty-eight states offer medical coverage or access to medical coverage to their Medicare-eligible retirees through some type of Medicare wraparound plan. In 25 of these states, this is the only coverage option offered by state governments to these retirees. Medicare wraparound coverage includes plans that pay for services not covered by Medicare and plans that reduce Medicare cost sharing, such as deductible and coinsurance payments.[94] Because these plans do not pay for costs reimbursed by Medicare, retirees must enroll in Medicare to receive comprehensive health coverage.

- **Medicare Advantage health plans.** Twenty-one states offer medical coverage or access to medical coverage to their Medicare-eligible retirees through Medicare Advantage (MA) plans designed to cover benefits under Medicare Parts A and B as well as provide wraparound coverage. This is the only type of coverage offered to Medicare-eligible retirees by eight of those 21 states.[95] With MA plans, states contract with an insurance company to offer group health insurance to their retirees.[96] The insurance company receives a per-enrollee, per-month payment from the federal Centers for Medicare & Medicaid Services (CMS), and the employer (and potentially the retiree, depending on cost-sharing provisions) pays the insurance company a premium for any additional services not covered by Medicare.[97] States benefit from offering MA plans because they are generally less expensive than individual wraparound plans.[98] However, states may choose not to offer an MA plan because, while they still make key decisions regarding participating insurance companies and plans offered, CMS regulates MA plans, so states have less control over the coverage they provide compared with wraparound plans.[99]

Figure 9

States' Methods for Covering Medicare-Eligible Retirees Vary

Types of health coverage



Note: Kentucky provides health coverage for Medicare-eligible retirees, but data on coverage type is unavailable. This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Prescription drug benefit coverage for Medicare-eligible retirees. Forty-four states offer prescription drug coverage or access to prescription drug coverage to their Medicare-eligible retirees.[100] States can offer prescription drug benefits for these retirees through a Retiree Drug Subsidy (RDS) Plan or through a Medicare Part D plan created for employers, called an Employer Group Waiver Plan (EGWP). (See "Glossary" box and Figure 10.)

The ACA and Medicare Part D

Prescription drug coverage for Medicare-eligible retirees under the Affordable Care Act, Part D EGWPs. When Medicare Part D prescription drug coverage was created, employers who already covered these benefits for their Medicare-eligible retirees were encouraged to continue this coverage by participating in either the RDS or EGWP programs. Both allow states to receive subsidies from the federal government in exchange for providing prescription drug coverage to Medicare-eligible retirees. Before implementation of the ACA, the RDS program was used more often by state government employers to provide prescription drug coverage to their retirees because of minimal requirements for participation.[101] However, the ACA made the EGWP program a more attractive option. Further, under GASB accounting rules, receipts from RDS programs are considered general revenue to the state or city government that cannot be included as a reduction to future costs when calculating the OPEB liability. By contrast, the GASB allows the direct cost savings expected in the future from the EGWP program to factor into OPEB liability calculations, resulting in lower OPEB liabilities compared with states that do not adopt EGWPs.[102]

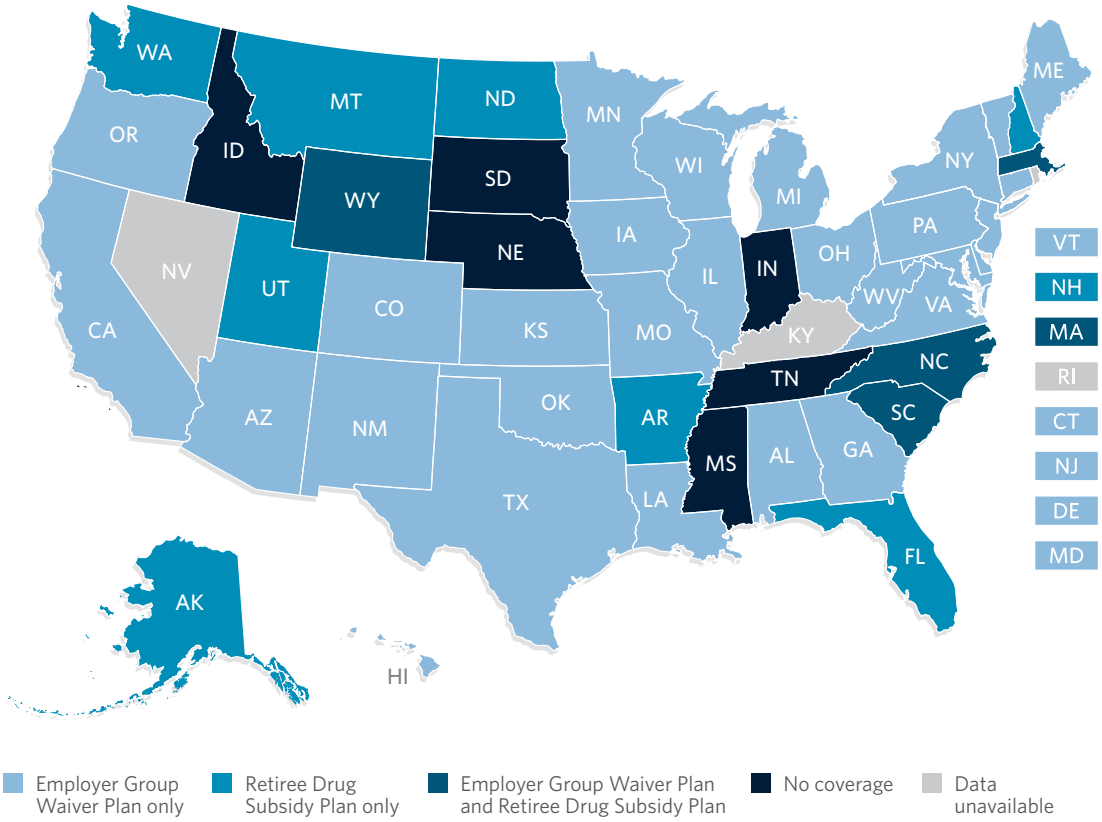
Part D prescription drug coverage under the ACA. The ACA allows for the gradual reduction of the Medicare Part D prescription drug coverage "doughnut hole"—the coverage gap between the initial coverage limit and the catastrophic coverage threshold—through 2020.[103]

- **RDS Plan.** Twelve states offer prescription drug coverage to their Medicare-eligible retirees through an RDS Plan. This is the only prescription coverage offered to such retirees in eight of these states. These states may receive a subsidy from Medicare to help offset their drug costs, because enrollees would otherwise participate in the federally subsidized Medicare Part D program.[104]
- **EGWP.** Thirty-three states offer prescription drug coverage to their Medicare-eligible retirees through an EGWP. These states offer either an EGWP-only plan or an EGWP through a Medicare Advantage prescription drug (MAPD) plan. The two options offer states similar prescription drug benefits. States that have elected to offer drug coverage through an EGWP or MAPD may offer retirees benefits that are the same as or better than a standard Part D plan; at the same time, they are reducing their OPEB liabilities by taking advantage of the 50 percent brand-name prescription drug discount available to all Medicare Part D programs.[105] In addition, eligible retirees in states that offer coverage through an EGWP benefit from reduced premiums and copays through the Low-Income Subsidy program for Medicare Part D.[106] Despite these advantages, some states have not switched to EGWPs because of the perceived administrative hurdles and fears that doing so would upset retirees who may mistakenly fear that any change would mean a net diminution of their prescription drug coverage.[107]

Figure 10

Many States Offer EGWPs for Medicare-Eligible Retirees

Breakdown of prescription drug coverage type



Note: Data on prescription drug coverage type for retirees in Kentucky, Nevada, and Rhode Island were not available. This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Medicare Part B premium contributions for Medicare-eligible retirees. As discussed above, despite having state-sponsored retiree health coverage, Medicare-eligible retirees must still enroll in—and pay a premium for—Medicare Part B health plans to receive comprehensive health coverage. In 2015, Medicare Part B premiums, determined by the federal government, ranged from $104.90 to $335.70 a month, based on the enrollee's income; however, 94 percent of all Medicare enrollees paid the minimum premium.[108] Some states—California, Connecticut, Hawaii, Maine, Nevada, New York, and Utah among them—contribute toward the Medicare Part B premiums for at least some Medicare-eligible retirees, in addition to any contribution they make toward the retirees' wraparound coverage. California makes a fixed-dollar contribution toward its Medicare-eligible retirees' wraparound premium. If that contribution exceeds the cost of this premium, the retiree can apply the excess toward his or her Medicare Part B premium. Nevada provides a contribution toward Medicare Part B premiums if the retiree is not eligible for premium-free Medicare Part A or if the retiree covers non-Medicare-eligible dependents and remains on the early retiree plan.

State changes to retiree health insurance plan provisions

As states continued over the past decade to balance maintaining a competitive workforce with fiscal constraints, they have refined their plan provisions. (See Appendix D.) Researchers analyzed changes to the criteria states use to determine eligibility for retiree health insurance plan coverage and state premium contributions for either early or Medicare-eligible retirees since 2000 and found the following:

- More than a dozen states changed the minimum age eligibility requirement, minimum years of service requirement for coverage, or both. In many cases, these modifications were tied to changes in state pension benefits.
- Based on our analysis, more than a dozen states also changed the minimum years of service requirement for state premium contribution eligibility or reduced the maximum state premium contribution.
- In addition, at least 10 states instituted prorating formulas that varied their levels of premium contribution based on years of service, or altered existing prorating formulas. Thirty-one states now use prorated benefit formulas for either early or Medicare-eligible retirees.
- At least five states—Alaska, Nevada, Oregon, Utah, and West Virginia—have eliminated state contributions to retiree health insurance premiums, whether for early or Medicare-eligible retiree coverage. These states continue to provide retirees with access to health care coverage.
- Idaho eliminated both state retiree health insurance plan coverage and state premium contributions for Medicare-eligible retirees.

Conclusion

While only 28 percent of large employers in the U.S. offer retiree health benefits, 49 states continue to include these benefits as a key part of state compensation programs, with years of service and other eligibility requirements set by the states. Many states also contribute to these retirees' health insurance premiums and set eligibility requirements for these contributions. This commitment over many years has grown into a large liability for states that the GASB recently addressed, imposing reporting requirements that require more accountability and transparency from participating states.

States have several options for addressing these liabilities, including establishing explicit policies to pre-fund their OPEB liabilities, amending retiree health plan provisions, and adopting cost-saving programs to provide medical and prescription drug coverage to Medicare-eligible retirees. States have accelerated their efforts in these areas, which have been aided over the past few years by a slowing in the growth of health care costs. However, as baby boomers retire in greater numbers and new high-cost, high-demand drugs come to market, costs may begin to rise at increased rates again.[109]

This 50-state report aims to assist policymakers and legislators in making difficult decisions about how best to use limited budget dollars by uncovering what strategies other states are trying and how successful they have been.

Appendix A: Methodology

Data sources

OPEB liabilities, funded ratios, funding policies, actual expenditures, and annual required contributions. The main data sources for this project were the Comprehensive Annual Financial Reports (CAFRs) produced by each state for fiscal 2008-13. The CAFR is published annually and details the state's financial status and other key state data. The Governmental Accounting Standards Board stipulates that the CAFR should include certain disclosures regarding other post-employment benefit finances.[110] Because CAFRs contain standard information in a consistent format, they are a valuable source for data on state-run retirement systems. In addition to the CAFR, many states release the actuarial valuation for their OPEB plans.[111] These are financial accounting reports that use actuarial methods and assumptions to calculate OPEB liabilities and fulfill GASB reporting requirements. In many cases, analysts found that the actuarial valuations offered more detailed data than did the state CAFRs and used these plan documents when available.

States primarily report costs of retiree health insurance benefits in their OPEB statements but may also include financial data on nonhealth benefits such as life and disability insurance. In addition, they may include financial data on OPEB for local retirees or teachers in localities where those plans are administered by the state or the state maintains a financial interest in them. In such instances, some benefit costs may be paid by a local school board, locality, or other nonstate entity.

Provisions of retiree health insurance plans. Project researchers collected data on provisions of retiree health insurance plans from various sources. When available, our primary sources were states' OPEB actuarial valuations. These documents outline the calculations made to assess current and future costs of retiree health insurance plans and describe plan provisions. Researchers also used information in state and plan CAFRs as well as documents states make available to stakeholders, including current and future retirees, on their retirement plan and retiree benefit websites. These documents come in several forms, chief among which are annual reports and benefit guides. Finally, in some instances data were not available, and the writers contacted state officials administering retiree health insurance plans or retirement systems directly.

Many states have multiple sets of eligibility rules for specific classes of employees such as teachers, firefighters, and elected officials. Project researchers collected and analyzed health plan provisions for only the main retiree health plans for general state employees.

Accuracy and comprehensiveness

To ensure the accuracy of the data presented in this report, project researchers implemented numerous quality control measures. First, researchers identified and double-checked all instances in which data changed significantly over time in the OPEB financial data and in which there were significant outliers in the health plan provision data, as a means of identifying potential errors in the transcription or interpretation of data. In addition, benefit administrators and retirement and finance officials in each state were given the opportunity to review OPEB and health plan provision data collected by project researchers for accuracy, and in many cases they offered useful feedback that was then incorporated into project data. This combined approach helps ensure that our research is based on well-vetted, accurate data.

Data analyses

Our analysis focused on annual cash payments for the OPEB plans and cost drivers that affect spending on retiree health insurance benefits. While project researchers collected data on 167 OPEB plans, each state's plans were aggregated to provide one set of OPEB numbers per state. Thus Massachusetts—which runs one OPEB plan for state and local employees—can be compared with Arkansas, which runs 22 OPEB plans.[112] As a result, our analysis shows broad national trends.

Percent change in OPEB liabilities from 2010 to 2013. To calculate the percent change in each state's OPEB liabilities from 2010 to 2013, researchers used aggregated data to get one value for each state's OPEB liability in 2010 and 2013, and adjusted the aggregated 2010 number for inflation using the 2013 gross domestic product deflator from the Bureau of Economic Analysis.[113]

Funded ratios by state. Project researchers aggregated CAFR data on each OPEB plan to get one value for each state's OPEB liabilities and OPEB assets. By dividing the total value of plan assets by the total liability, the research team arrived at each state's funded ratio for OPEB.

State OPEB liabilities and state personal income. To calculate each state's aggregate OPEB liabilities as a percentage of state personal income, project researchers compared the total actuarial accrued liabilities for all of a state's OPEB plans in 2013 to the personal income data available online through the Bureau of Economic Analysis, adjusted to match each state's fiscal year.[114]

State OPEB liabilities compared with state population. The research team compared states' annual population estimates with their OPEB liabilities in 2013 to show that a small number of states represent a large portion of the national aggregate OPEB liability.[115]

State-generated revenue. The research team used State Government Finances data from the U.S. Census Bureau to calculate state-generated revenue for each state.[116] Researchers used CAFR data, the Milliman Atlas of Public Employer Health Plans, and data from CMS to calculate the annual required contribution, active state employee health plan spending, and state Medicaid spending as a percentage of state-generated revenue.[117]

Percentage of annual required contribution paid. The research team used states' aggregate actual expenditures for OPEB and annual required contributions to OPEB reported in state and plan CAFRs to calculate each state's actual expenditures as a percentage of the annual required contribution.

Changes to retiree health insurance plans over time. Project researchers reviewed financial documents from 2010 onward as well as other sources to determine recent benefit provisions, generally applicable in or after 2000. In 18 states, documents used to analyze retiree health plan data described a single set of criteria to determine eligibility for coverage and the level of any premium contribution for retirees. For the remaining 32 states, multiple sets of criteria are described, varying by a worker's date of hire, date of retirement, or vesting eligibility. For these states, we analyzed two representative sets of criteria: the most recent benefits applicable to a cohort of either new retirees or new hires, and a second set of criteria to provide a point of comparison for how benefits have changed in recent years. For each state, we presented the most recent data available as of February 2015.

Appendix B: 50-state OPEB financial data tables

Table B.1

State OPEB Liabilities and Funded Ratios, 2010-13

State	2010 liability (in thousands)	2013 liability (in thousands)	Funded ratio			
			2010	2011	2012	2013
Alabama	$15,747,241	$12,459,751	5%	7% ↑	9% ↑	10% ↑
Alaska	$12,419,995	$17,403,632	50%	52% ↑	47% ↓	43% ↓
Arizona	$2,284,190	$2,201,974	69%	67% ↓	68% ↑	73% ↑
Arkansas	$1,857,585	$2,148,523	0%	0% →	0% →	0% →
California	$78,357,696	$80,312,348	0%	0% →	0% →	0% →
Colorado	$2,014,397	$2,135,758	15%	13% ↓	13% →	14% ↑
Connecticut	$26,697,800	$22,724,600	0%	0% →	0% →	1% ↑
Delaware	$5,884,000	$5,988,000	2%	2% →	3% ↑	4% ↑
Florida	$4,545,845	$7,487,707	0%	0% →	0% →	0% →
Georgia	$19,844,619	$19,264,310	4%	5% ↑	5% →	6% ↑
Hawaii	$15,857,429	$13,671,926	0%	0% →	0% →	0% →
Idaho	$156,280	$134,980	12%	12% →	15% ↑	21% ↑
Illinois	$43,949,729	$56,329,888	0%	0% →	0% →	0% →
Indiana	$524,859	$387,991	0%	5% ↑	18% ↑	19% ↑
Iowa	$538,181	$526,389	0%	0% →	0% →	0% →
Kansas	$562,152	$546,750	2%	2% →	3% ↑	3% →
Kentucky	$8,754,555	$6,429,092	15%	15% →	19% ↑	25% ↑
Louisiana	$11,527,958	$8,543,177	0%	0% →	0% →	0% →
Maine	$2,625,058	$2,054,269	6%	7% ↑	9% ↑	11% ↑
Maryland	$16,530,102	$9,014,484	1%	2% ↑	2% →	2% →
Massachusetts	$15,166,300	$15,784,100	2%	2% →	2% →	3% ↑
Michigan	$45,476,000	$24,554,500	2%	3% ↑	7% ↑	11% ↑
Minnesota	$1,216,649	$1,010,739	0%	0% →	0% →	0% →
Mississippi	$727,711	$690,339	0%	0% →	0% →	0% →
Missouri	$3,180,260	$3,303,289	3%	4% ↑	4% →	4% →

Continued on the next page

State	2010 liability (in thousands)	2013 liability (in thousands)	Funded ratio			
			2010	2011	2012	2013
Montana	$540,894	$447,105	0%	0% →	0% →	0% →
Nebraska*	—	—	—	—	—	—
Nevada	$1,706,543	$1,271,752	2%	3% ↑	0% ↓	0% →
New Hampshire	$3,291,683	$2,588,586	2%	1% ↓	1% →	1% →
New Jersey	$71,371,700	$66,804,600	0%	0% →	0% →	0% →
New Mexico	$3,523,665	$3,915,114	5%	5% →	6% ↑	6% →
New York	$56,826,000	$69,514,000	0%	0% →	0% →	0% →
North Carolina	$33,993,147	$26,943,108	3%	4% ↑	5% ↑	5% →
North Dakota	$161,982	$153,522	30%	30% →	32% ↑	43% ↑
Ohio	$39,569,177	$24,887,007	39%	42% ↑	65% ↑	63% ↓
Oklahoma	$2,918	$4,621	0%	0% →	0% →	0% →
Oregon	$768,865	$639,900	31%	36% ↑	43% ↑	56% ↑
Pennsylvania	$17,465,836	$18,875,393	1%	1% →	1% →	1% →
Rhode Island	$833,141	$778,322	0%	2% ↑	2% →	8% ↑
South Carolina	$9,657,947	$10,101,175	5%	5% →	6% ↑	7% ↑
South Dakota	$70,548	$67,774	0%	0% →	0% →	0% →
Tennessee	$1,560,848	$1,442,208	0%	0% →	0% →	0% →
Texas	$55,949,044	$61,729,417	1%	2% ↑	1% ↓	1% →
Utah	$510,765	$428,828	22%	22% →	37% ↑	37% →
Vermont	$1,628,934	$1,660,530	0%	1% ↑	1% →	1% →
Virginia	$6,528,000	$6,539,340	23%	22% ↓	18% ↓	21% ↑
Washington	$7,618,372	$7,381,134	0%	0% →	0% →	0% →
West Virginia	$7,410,241	$3,262,553	6%	12% ↑	12% →	18% ↑
Wisconsin	$2,492,932	$2,241,604	40%	48% ↑	47% ↓	52% ↑
Wyoming	$246,571	$243,197	0%	0% →	0% →	0% →
National Aggregate	$660,176,344	$627,029,306	5%	5% →	6% ↑	6% →

* Nebraska does not report an OPEB liability.

Note: Data are not adjusted for inflation. Numbers reported in this table may differ from those in the report due to rounding. The national aggregate liability for 2010 in 2013 dollars is $696 billion.

Source: Analysis of data from states' Comprehensive Annual Financial Reports, actuarial reports and valuations, other public documents, or from plan officials

Table B.2

State OPEB Expenditures and Annual Required Contributions, 2013

State	Actual expenditures (in thousands)	ARC (in thousands)	Percentage of ARC contributed
Alabama	$457,262	$1,054,957	43%
Alaska	$535,364	$950,125	56%
Arizona	$155,746	$155,746	100%
Arkansas	$58,907	$228,302	26%
California	$2,196,269	$6,658,035	33%
Colorado	$94,807	$149,073	64%
Connecticut	$569,655	$1,451,739	39%
Delaware	$209,200	$483,800	43%
Florida	$128,999	$452,658	28%
Georgia	$627,431	$1,683,339	37%
Hawaii	$277,900	$994,893	28%
Idaho	$10,347	$12,773	81%
Illinois	$855,978	$4,003,399	21%
Indiana	$19,313	$32,240	60%
Iowa	$26,004	$56,691	46%
Kansas	$66,001	$87,344	76%
Kentucky	$383,596	$528,989	73%
Louisiana	$271,002	$583,525	46%
Maine	$100,716	$148,644	68%
Maryland	$407,225	$704,977	58%
Massachusetts	$584,800	$1,250,900	47%
Michigan	$1,777,548	$2,270,599	78%
Minnesota	$60,447	$116,980	52%
Mississippi	$29,490	$44,906	66%
Missouri	$107,131	$267,054	40%
Montana*	$0	$45,031	0%

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State	Actual expenditures (in thousands)	ARC (in thousands)	Percentage of ARC contributed
Nebraska	NA	NA	NA
Nevada	$59,029	$140,846	42%
New Hampshire	$101,044	$182,043	56%
New Jersey	$1,838,500	$6,351,000	29%
New Mexico	$135,388	$353,658	38%
New York	$1,446,000	$3,399,000	43%
North Carolina	$912,896	$2,085,091	44%
North Dakota	$13,543	$16,134	84%
Ohio	$329,478	$1,724,138	19%
Oklahoma	$187	$328	57%
Oregon	$60,651	$72,500	84%
Pennsylvania	$831,963	$1,281,086	65%
Rhode Island	$58,223	$58,223	100%
South Carolina	$416,388	$828,271	50%
South Dakota	$3,649	$7,771	47%
Tennessee	$69,984	$152,018	46%
Texas	$1,271,608	$4,640,128	27%
Utah	$40,385	$39,773	102%
Vermont	$25,558	$113,435	23%
Virginia	$379,941	$592,531	64%
Washington	$135,729	$683,798	20%
West Virginia	$171,221	$289,725	59%
Wisconsin	$95,832	$190,485	50%
Wyoming	$9,106	$19,242	47%
National Aggregate	$18,417,442	$47,637,945	39%

* Montana did not make an OPEB contribution in 2013.

NA: Nebraska does not report an OPEB liability, annual required contributions to OPEB, or actual OPEB expenditures.

Note: Numbers reported in this table may differ from those in the report due to rounding.

Source: Analysis of data from states' Comprehensive Annual Financial Reports, actuarial reports and valuations, other public documents, or from plan officials

Appendix C: OPEB funding policies and retiree health plan eligibility

This appendix describes health insurance benefits for a public worker hired today. In some instances these have been the benefit parameters in place for years, in others they represent recent policy changes.

Table C.1

50-State Matrix for Early Retirees

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA*	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO
Funded ratios																									
Below 1%				✓	✓		✓		✓		✓		✓		✓			✓					✓	✓	
1-9%	✓							✓		✓						✓				✓	✓				✓
10-29%						✓						✓		✓			✓		✓			✓			
30% and above		✓	✓																						
State premium contributions																									
Fixed-dollar premium contributions			✓	✓		✓									✓		✓								
Contribution tied to total premium cost	✓				✓		✓	✓		✓	✓		✓					✓	✓	✓	✓	✓			✓
No state contribution		✓							✓			✓		✓		✓							✓	✓	
Premium contributions prorated	✓		✓		✓	✓	✓	✓		✓	✓		✓		✓		✓	✓		✓		✓			✓
Minimum years of service (YOS) for premium contribution																									
Less than 10 years			✓	✓		✓									✓			✓							
10 years	✓				✓					✓	✓		✓							✓	✓	✓			✓
11-20 years							✓	✓									✓								
Greater than 20 years																			✓						
Retiree dependents																									
Access to health care coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Premium contribution provided	✓		✓	✓	✓		✓	✓		✓			✓		✓			✓		✓	✓	✓			✓

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	MT	NE†	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Funded ratios																									
Below 1%	✓		✓	✓	✓		✓				✓					✓	✓	✓		✓		✓			✓
1-9%						✓		✓					✓	✓	✓										
10-29%																					✓		✓		
30% and above									✓	✓		✓							✓					✓	
State premium contributions																									
Fixed-dollar premium contributions									✓		✓										✓				✓
Contribution tied to total premium cost				✓	✓	✓	✓	✓		✓			✓	✓	✓		✓	✓		✓					
No state contribution	✓	✓	✓									✓				✓			✓			✓	✓	✓	
Premium contributions prorated					✓	✓	✓	✓	✓	✓			✓	✓	✓		✓	✓		✓	✓				✓
Minimum years of service (YOS) for premium contribution																									
Less than 10 years						✓			✓		✓														✓
10 years							✓	✓										✓		✓					
11-20 years				✓						✓			✓	✓	✓		✓				✓				
Greater than 20 years					✓																				
Retiree dependents																									
Access to health care coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Premium contribution provided				✓	✓	✓	✓		✓	✓			✓		✓		✓	✓		✓					

Notes: This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

* Iowa provides a credit for unused sick leave.

† Nebraska does not report an OPEB liability.

Source: Analysis of data from states' Comprehensive Annual Financial Reports, actuarial reports and valuations, and analysis of publicly available retiree health benefit plan data, verified by states. (See Appendix A.)

Table C.2

50-State Matrix for Medicare-Eligible Retirees

	AL	AK	AZ	AR	CA	CO	CT	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY*†	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE‡	NV*
Funded ratios																												
Below 1%				✓	✓		✓		✓		✓		✓		✓			✓					✓	✓		✓		✓
1-9%	✓							✓		✓						✓				✓	✓				✓			
10-29%						✓						✓		✓			✓		✓			✓						
30% and above		✓	✓																									
State premium contributions																												
Fixed-dollar premium contributions			✓	✓		✓											✓											
Contribution tied to total premium cost	✓	✓			✓		✓	✓		✓	✓		✓					✓	✓	✓	✓	✓			✓			
No state contribution									✓			✓		✓	✓	✓							✓	✓		✓	✓	✓
Premium contributions prorated	✓	✓	✓		✓	✓		✓		✓	✓		✓				✓	✓	✓	✓		✓			✓			
Minimum years of service (YOS) for premium contribution																												
Less than 10 years			✓	✓		✓												✓										
10 years	✓	✓			✓					✓	✓		✓							✓	✓	✓			✓			
11-20 years							✓	✓									✓											
Greater than 20 years																			✓									
Retiree dependents																												
Access to health care coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Premium contribution provided	✓	✓	✓	✓	✓		✓	✓		✓			✓					✓		✓	✓	✓			✓			
Health coverage type																												
Medicare wraparound	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓		✓		✓	✓	✓		✓	✓	✓		✓
Medicare Advantage health plan			✓		✓	✓			✓	✓	✓		✓			✓		✓	✓		✓		✓					✓
No medical coverage												✓		✓													✓	
Prescription drug coverage type																												
Employer Group Waiver Plan or Medicare Advantage prescription drug plan	✓		✓		✓	✓	✓	✓		✓	✓		✓		✓	✓		✓	✓	✓	✓	✓	✓		✓			
Retiree drug subsidy plan		✓		✓					✓												✓					✓		
No prescription drug coverage												✓		✓										✓			✓	

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	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI*	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Funded ratios																						
Below 1%	✓	✓		✓				✓					✓	✓	✓		✓		✓			✓
1-9%			✓		✓					✓	✓	✓										
10-29%																		✓		✓		
30% and above						✓	✓		✓							✓					✓	
State premium contributions																						
Fixed-dollar premium contributions						✓		✓						✓				✓	✓			✓
Contribution tied to total premium cost	✓	✓	✓	✓	✓		✓			✓	✓	✓			✓		✓					
No state contribution									✓				✓			✓				✓	✓	
Premium contributions prorated		✓	✓	✓	✓	✓	✓			✓		✓		✓	✓		✓	✓				✓
Minimum years of service (YOS) for premium contribution																						
Less than 10 years			✓			✓		✓											✓			✓
10 years				✓	✓										✓		✓					
11-20 years	✓						✓			✓	✓	✓		✓				✓				
Greater than 20 years		✓																				
Retiree dependents																						
Access to health care coverage	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Premium contribution provided	✓	✓	✓	✓		✓	✓			✓		✓		✓	✓		✓					
Health coverage type																						
Medicare wraparound	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Medicare Advantage health plan		✓	✓		✓		✓		✓	✓					✓					✓		
No medical coverage																						
Prescription drug coverage type																						
Employer Group Waiver Plan or Medicare Advantage prescription drug plan		✓	✓	✓	✓		✓	✓	✓	✓		✓			✓		✓	✓		✓	✓	✓
Retiree drug subsidy plan	✓				✓	✓						✓				✓			✓			✓
No prescription drug coverage													✓	✓								

Notes: This reflects the most recent set of benefits as instituted by states at the time of our data collection as of February 2015. See Appendix D to learn to which retirees these data are applicable, by state.

* Data on prescription drug coverage type for Medicare-eligible retirees in Kentucky, Nevada, and Rhode Island are not available.

† Kentucky did not report on Medicare-eligible retiree health coverage type.

‡ Nebraska does not report an OPEB liability.

Source: Analysis of data from states' Comprehensive Annual Financial Reports, actuarial valuations, and analysis of publicly available retiree health benefit plan data, verified by states. (See Appendix A.)

Appendix D: State contributions to retiree health insurance plans

This appendix outlines the most recent premium contribution criteria for early and Medicare-eligible retirees in each state at the time of our data collection as of February 2015.[118] Most states provide varying levels of retiree benefits based on factors such as date of hire, date of retirement, or vesting eligibility. The table below describes the eligibility and premium contribution criteria analyzed in this report as defined by each state. See Appendix A to review the methodology researchers used to determine which groups were included in the analysis. Data were collected from publicly available documents related to retiree health plans and were verified with states. If a state did not verify a particular plan provision, that is noted.

Table D

Criteria for State Premium Contributions to Retiree Health Insurance Plans

State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Alabama	Retired on or after Jan. 1, 2012	Early retirees	Average employer contribution: $5,412	Based on years of creditable coverage and number of years below age 65; state pays full state share at 65 with 25 YOS
	Retired on or after Jan. 1, 2012	Medicare-eligible retirees	Average employer contribution: $4,152	Based on years of creditable coverage; state pays full state share at 25 YOS
Alaska	Hired after June 30, 2006	Early retirees	0%	NA
	Hired after June 30, 2006	Medicare-eligible retirees	70-90%	10 YOS = 70%; 15 YOS = 75%; 20 YOS = 80%; 25 YOS = 85%; 30 YOS = 90%
Arizona	Current retirees	Early retirees	$900-$1,800	Retirees receive a percentage of a fixed-dollar amount based on YOS: 5 YOS = $900 (50%); each additional YOS adds $180 (10%), up to $1,800 (100%)
	Current retirees	Medicare-eligible retirees	$600-$1,200	5 YOS = $600; each additional YOS adds $120, up to $1,200 (i.e., 5 YOS = 50% of benefit; 6 YOS = 60%; 10 YOS = 100%)
Arkansas	All retirees beginning Jan. 1, 2015	Early retirees	$1,972	None
	All retirees beginning Jan. 1, 2015	Medicare-eligible retirees	$2,225	None
California	Hired on or after Jan. 1, 1989	Early retirees	0-100% of a flat subsidy of $7,704	10 YOS = 50% of subsidy; then 5% per YOS, up to 100%
	Hired on or after Jan. 1, 1989	Medicare-eligible retirees	0-100% of a flat subsidy of $7,704	10 YOS = 50% of subsidy; then 5% per YOS, up to 100%

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Colorado	Current retirees	Early retirees	$690 to $2,760	$11.50 per month per YOS, up to $2,760
	Current retirees	Medicare-eligible retirees	$69 to $1,380	$5.75 per month per YOS, up to $1,380
Connecticut	Hired on or after July 1, 2011	Early retirees	60-100%	For retirees in "normal retirement," the state contribution is 98.5% of the point-of-service benefit plan or 100% of the point-of-enrollment benefit plan. For retirees in "early retirement," the state contribution is based on YOS and number of years below normal retirement age (63 or 65 depending on YOS).
	Hired on or after July 1, 2011	Medicare-eligible retirees	100%	None
Delaware	Hired on or after Jan. 1, 2007	Early retirees	0-100% of 96% premium contribution	The state share of the contribution is prorated: Less than 15 YOS = 0%; 15-17.5 YOS = 50%; 17.6-19 YOS = 75%; 20 or more YOS = 100% (100% subsidy level is 96% of premium for retirees)
	Hired on or after Jan. 1, 2007 and retired after July 1, 2012	Medicare-eligible retirees	0-100% of 95% premium contribution	The state share of the contribution is prorated: Less than 15 YOS = 0%; 15-17.5 YOS = 50%; 17.6-19 YOS = 75%; 20 or more YOS = 100% (100% subsidy level is 95% of premium for retirees)
Florida	Enrolled on or after July 1, 2011*	Early retirees	0%	NA
	Enrolled on or after July 1, 2011*	Medicare-eligible retirees	0%	NA
Georgia	Employed on or after Jan. 1, 2009	Early retirees	0-75%	75%-3%*(30-YOS); capped at 75%
	Employed on or after Jan. 1, 2009	Medicare-eligible retirees	0-75%	75%-3%*(30-YOS); capped at 75%
Hawaii	Hired on or after July 1, 2012	Early retirees	0-100% of a flat rate of $8,839	10 YOS = 50%; 15 YOS = 75%; 25 or more YOS = 100%
	Hired on or after July 1, 2012	Medicare-eligible retirees	0-100% of a flat rate of $6,297	Part B premium covered at 100%; supplemental premiums are prorated: 10 YOS = 50%; 15 YOS = 75%; 25 or more YOS = 100%
Idaho	Hired on or after June 30, 2009	Early retirees	NA	NA
	All retirees beginning Jan. 1, 2010	Medicare-eligible retirees	NA	NA
Illinois	Hired after Dec. 31, 2010	Early retirees	50-100%	The state contributes 5% of the premium for each YOS
	Hired after Dec. 31, 2010	Medicare-eligible retirees	50-100%	The state contributes 5% of the premium for each YOS

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Indiana	Current retirees	Early retirees	0%	NA
	Current retirees	Medicare-eligible retirees	NA	NA
Iowa	Vested after July 1, 2012	Early retirees	85-100% until sick leave credits are depleted	Sick Leave Insurance Program: An amount is deposited in the retiree's account based on the unused sick leave remaining and retiree regular hourly rate of pay upon retirement; retirees may use this to pay for up to 100% of retiree-only health insurance premiums until there are no more funds remaining. Then the retiree is responsible for 100% of the premium.
	Vested after July 1, 2012	Medicare-eligible retirees	0%	NA
Kansas†	Tier 1: Hired before July 1, 2009; Tier 2: Hired after July 1, 2009	Early retirees	0%	NA
	Tier 1: Hired before July 1, 2009; Tier 2: Hired after July 1, 2009	Medicare-eligible retirees	0%	NA
Kentucky	Hired on or after Jan. 1, 2014	Early retirees	$1,800 and up (no maximum)	$120 times YOS
	Hired on or after Jan. 1, 2014	Medicare-eligible retirees	$1,800 and up (no maximum)	$120 times YOS
Louisiana	Hired after Jan. 1, 2011	Early retirees	19-75%	5-9 YOS = 19%; 10-14 YOS = 38%; 15-19 YOS = 56%; 20 or more YOS = 75%
	Hired after Jan. 1, 2011	Medicare-eligible retirees	19-75% or $2,400 flat rate	5-9 YOS = 19%; 10-14 YOS = 38%; 15-19 YOS = 56%; 20 or more YOS = 75% (percentage of total premium) or Medicare eligibles who move to a One Exchange plan receive $200 monthly credited to a Health Reimbursement Arrangement and forgo the 19-75% premium contribution.
Maine	Hired on or after July 1, 2011	Early retirees	100%	None
	Hired on or after July 1, 2011	Medicare-eligible retirees	0-100%	Based on years of medical coverage: 0-9 = 0%; 10-14 = 50%; 15-19 = 75%; 20 or more = 100%

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Maryland	Hired on or after July 1, 2011	Early retirees	40-100% of flat-rate subsidy	40% of flat subsidy at 10 YOS + 4% more per YOS up to 100%; actual number of months worked is divided into the number of months needed for full subsidy (300 months)
	Hired on or after July 1, 2011	Medicare-eligible retirees	40-100% of flat-rate subsidy	40% of flat subsidy at 10 YOS + 4% more per YOS up to 100%; actual number of months worked is divided into the number of months needed for full subsidy (300 months)
Massachusetts	Retired after Oct. 1, 2009	Early retirees	80%	None
	Retired after Oct. 1, 2009	Medicare-eligible retirees	80%	None
Michigan	Current retirees	Early retirees	30-80%	30% at 10 YOS + (3% times YOS after 10 YOS), capped at 80%
	Current retirees	Medicare-eligible retirees	30-80%	30% at 10 YOS + (3% times YOS after 10 YOS), capped at 80%
Minnesota	Current retirees	Early retirees	0%	NA
	Current retirees	Medicare-eligible retirees	0%	NA
Mississippi	Current retirees	Early retirees	0%	NA
	Current retirees	Medicare-eligible retirees	0%	NA
Missouri	Hired on or after Jan. 1, 2011	Early retirees	25-65%	YOS times 2.5% of PPO 600 Plan premium, capped at 65%
	Hired on or after Jan. 1, 2011	Medicare-eligible retirees	25-65%	YOS times 2.5% of PPO 600 Plan premium, capped at 65%
Montana	Current retirees	Early retirees	0%	NA
	Current retirees	Medicare-eligible retirees	0%	NA
Nebraska	Current retirees	Early retirees	0%	NA
	Current retirees	Medicare-eligible retirees	NA	NA
Nevada	Hired after Jan. 1, 2012	Early retirees	0%	NA
	Hired after Jan. 1, 2012	Medicare-eligible retirees	0%	NA
New Hampshire	Hired after July 1, 2011	Early retirees	87.5%	None
	Hired after July 1, 2011	Medicare-eligible retirees	100%	None

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
New Jersey	Less than 20 YOS as of July 1, 2011	Early retirees	Difference between premium and 4.5-35% of retirees' pension	Based on retiree pension
	Less than 20 YOS as of July 1, 2011	Medicare-eligible retirees	Difference between premium and 4.5-35% of retirees' pension	Based on retiree pension
New Mexico	Current retirees	Early retirees	6.25-100% of 65% premium contribution	6.25% at 5 years + (6.25% times YOS after 5 years); maxed at 20 years; (100% subsidy level is 65% of premium for retirees)
	Current retirees	Medicare-eligible retirees	6.25-100% of 50% premium contribution	6.25% at 5 years + (6.25% times YOS after 5 years); maxed at 20 years; (100% subsidy level is 50% of premium for retirees)
New York	Retired on or after Jan. 1, 2012	Early retirees	84-88%	Based on employee grade; grades 1-9 = 88%; grades 10 or higher = 84%
	Retired on or after Jan. 1, 2012	Medicare-eligible retirees	84-88%	Based on employee grade; grades 1-9 = 88%; grades 10 or higher = 84%
North Carolina	Hired after Oct. 1, 2006	Early retirees	0-100% of state contribution of $5,378	State contribution $5,378: 5-9 YOS = 0% of contribution; 10-19 YOS = 50% of contribution; 20 or more YOS = 100% of contribution
	Hired after Oct. 1, 2006	Medicare-eligible retirees	0-100% of state contribution of $4,179	State contribution $4,179: 5-9 YOS = 0% of contribution; 10-19 YOS = 50% of contribution; 20 or more YOS = 100% of contribution
North Dakota	Current retirees	Early retirees	$77.40 and up (no maximum)	State contribution is $60 per year per YOS up to the total premium amount; the state's contribution is reduced based on age
	Current retirees	Medicare-eligible retirees	$60 and up (no maximum)	$60 per year per YOS up to the total premium amount
Ohio	Retired after December 2014/ Jan. 1, 2015	Early retirees	51-90%	51% + 2% for each YOS over 20 years + 3% per year of age over 60; maximum is 90%
	Retired after December 2014/ Jan. 1, 2015	Medicare-eligible retirees	66-90%	66% + 2% for each YOS over 20 years; maximum is 90%
Oklahoma	Current retirees	Early retirees	Lesser of $1,260 flat subsidy or premium amount	None
	Current retirees	Medicare-eligible retirees	Lesser of $1,260 flat subsidy or Medicare Supplemental premium amount	None
Oregon	Hired on or after Aug. 29, 2003	Early retirees	0%	NA
	Hired on or after Aug. 29, 2003	Medicare-eligible retirees	0%	NA

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Pennsylvania	Retired on or after July 1, 2011	Early retirees	Varies	Retirees pay 3% of final average salary
	Retired on or after July 1, 2011	Medicare-eligible retirees	Varies	Retirees pay 1.5% of final average salary
Rhode Island†	Less than 5 YOS after June 30, 2012	Early retirees	0-80%	0% for retirees below age 59; 80% for retirees 59 and older
	Less than 5 YOS after June 30, 2012	Medicare-eligible retirees	80%	None
South Carolina	Hired on or after May 2, 2008	Early retirees	0-100% of 72% premium contribution	5-14 YOS = 0%; 15-24 YOS = 50%; 25 YOS =100% (100% subsidy level is 72% of premium for retirees)
	Hired on or after May 2, 2008	Medicare-eligible retirees	0-100% of 72% premium contribution	5-14 YOS = 0%; 15-24 YOS = 50%; 25 YOS =100% (100% subsidy level is 72% of premium for retirees)
South Dakota	Retired on or after Nov. 1, 2014	Early retirees	0%	NA
	Retired on or after Nov. 1, 2014	Medicare-eligible retirees	0%	NA
Tennessee	Current retirees	Early retirees	60-80% of the lowest priced plan	15-19 YOS = 60%; 20-29 YOS = 70%; 30 YOS = 80%
	Current retirees	Medicare-eligible retirees	$300-$600	15-19 YOS = $25 per month; 20-29 YOS = $37.50 per month; 30 YOS = $50 per month
Texas	Future retirees with less than 5 YOS on Aug. 31, 2014	Early retirees	FY 2015 rates: $235.89 to $541.70 (also varies depending on plan selected)	The difference between the total premium and the annually established retiree contribution, which varies based on YOS as of Sept. 1, 2014: 10-14 YOS = 50%, 15-19 YOS = 75%; 20 or more YOS = 100%
	Future retirees with less than 5 YOS on Aug. 31, 2014	Medicare-eligible retirees	FY 2015 rates: $235.89 to $541.70 (also varies depending on plan selected)	The difference between the total premium and the annually established retiree contribution, which varies based on YOS as of Sept. 1, 2014: 10-14 YOS = 50%, 15-19 YOS = 75%; 20 or more YOS = 100%
Utah	Hired on or after Jan. 1, 2014	Early retirees	0%	State phasing out contributions toward any insurance after retirement
	Hired on or after Jan. 1, 2014	Medicare-eligible retirees	0%	NA
Vermont	Hired on or after July 1, 2008	Early retirees	0-80%	0-9 YOS = 0%; 10-14 YOS = 40%; 15-19 YOS = 60%; 20 or more YOS = 80%
	Hired on or after July 1, 2008	Medicare-eligible retirees	0-80%	0-9 YOS = 0%; 10-14 YOS = 40%; 15-19 YOS = 60%; 20 or more YOS = 80%

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State	Hire or retirement date	Category	Premium contribution range per retiree per year	Prorating description
Virginia	Current retirees	Early retirees	$720 and up (no maximum)	$48 times YOS, no cap
	Current retirees	Medicare-eligible retirees	$720 and up (no maximum)	$48 times YOS, no cap
Washington	PERS Plan 3 members hired on or after March 1, 2002	Early retirees	0%	NA
	PERS Plan 3 members hired on or after March 1, 2002	Medicare-eligible retirees	Lesser of 50% or $1,800	None
West Virginia	Hired on or after July 1, 2010	Early retirees	0%	NA
	Hired on or after July 1, 2010	Medicare-eligible retirees	0%	NA
Wisconsin	Hired after July 1, 2011	Early retirees	0%	NA
	Hired after July 1, 2011	Medicare-eligible retirees	0%	NA
Wyoming	Current retirees	Early retirees	$552-$4,140	$11.50 per month times YOS, maxed at 30 YOS
	Current retirees	Medicare-eligible retirees	$276 to $2,070	$5.75 per month times YOS, maxed at 30 YOS

Note: YOS = years of service; PERS = Public Employees' Retirement System.

* Retirees in Florida can apply to be enrolled in the Health Insurance Subsidy Program that is considered a pension benefit.

† Kansas and Rhode Island did not verify the data in this table.

Source: Analysis of publicly available data on retiree health benefit plans, verified by states. (See Appendix A.)

Endnotes

See Appendix D to learn to which retirees these data are applicable, by state. See Appendix A to review the methodology researchers used to determine which groups of retirees were included in the analysis.

1 Idaho does not offer coverage to Medicare-eligible retirees and does not offer coverage to retirees not yet eligible for Medicare who were hired after June 30, 2009, with less than 10 years of credited state service. However, it does provide coverage and a premium contribution to retirees who were hired before July 1, 2009, and are not yet eligible for Medicare. Most states provide varying levels of retiree benefits based on rules such as date of hire, date of retirement, or vesting eligibility.

2 Frank McArdle, Tricia Neuman, and Jennifer Huang, *Retiree Health Benefits at the Crossroads*, Henry J. Kaiser Family Foundation (April 2014), http://kff.org/medicare/report/retiree-health-benefits-at-the-crossroads.

3 Jerrell D. Coggburn, Dennis M. Daley, and Richard C. Kearney, "Public Sector Retiree Health Care Benefits: A View From the American States," *Public Personnel Management* 41, no. 2 (2012): 219–40, http://ipma-hr.org/sites/default/files/pdf/ppm/ppmsum2012.pdf; and The Pew Charitable Trusts and the Laura and John Arnold Foundation, "Recruiting and Retaining Public Sector Workers: Views From State Personnel Executives" (2014), http://www.pewtrusts.org/~/media/Assets/2014/09/RecruitingandRetainingPublicSectorWorkersIssueBrief.pdf.

4 Governmental Accounting Standards Board, "Summary of Statement No. 45," accessed May 15, 2015, http://www.gasb.org/st/summary/gstsm45.html. The GASB is an independent organization, not a government entity, that establishes and updates standards of accounting and financial reporting for U.S. state and local governments. Its standards do not have the force of federal law or regulation, nor does GASB have enforcement authority. Compliance with its standards, however, is enforced through the laws of some states.

5 Ibid. Standards were issued in 2004, but implementation requirements for all applicable governmental entities were phased in between 2006 and 2008. Standard & Poor's Ratings Services, "Diverging Trends Underlie Stable Overall U.S. OPEB Liability" (2014), 2, http://www.nasra.org/Files/Topical%20Reports/OPEB/SandP%20State%20OPEB%20report%2011-17-14.pdf.

6 Standard & Poor's Ratings Services, "Diverging Trends," 2.

7 Governmental Accounting Standards Board, *Other Postemployment Benefits: A Plain-Language Summary of GASB Statements No. 43 and No. 45*, 8, accessed May 15, 2015, http://www.gasb.org/resources/ccurl/553/517/opeb_summary.pdf; and Government Finance Officers Association, "Considerations for Prefunding OPEB Obligations," accessed May 15, 2015, http://www.gfoa.org/considerations-prefunding-opeb-obligations.

8 Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, 108th Congress (2003), http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/html/PLAW-108publ173.htm.

9 McArdle, Neuman, and Huang, *Retiree Health Benefits*; and Centers for Medicare & Medicaid Services, "What's Medicare Supplement Insurance (Medigap)?" accessed May 15, 2015, http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html.

10 Governmental Accounting Standards Board, *Other Postemployment Benefits*, 4.

11 American Academy of Actuaries, "Measuring Pension Obligations" (2013), 1, http://www.actuary.org/files/IB_Measuring-Pension-Obligations_Nov-21-2013.pdf.

12 Steven P. May and David M. Liner, "EGWP/Wrap: Why Now?" (2011), http://us.milliman.com/uploadedFiles/insight/research/health-rr/egwp-wrap-why-now.pdf.

13 Ibid.

14 Jennifer Rak and Sarika Kasaraneni, "The Value of Medicare Advantage Employer Group Waiver Plans (MA-EGWPs) for Employers and Retirees," Avalere Health (2014), http://avalere.com/expertise/managed-care/insights/employers-value-medicare-advantage-employer-group-waiver-plans-ma-egwps-as; and American Medical Association, "Capitation," accessed Oct. 2, 2015, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/capitation.page.

15 Rak and Kasaraneni, "The Value of Medicare Advantage"; and American Medical Association, "Capitation."

16 Governmental Accounting Standards Board, "Summary of Statement No. 45"; and Standard & Poor's Ratings Services, "Diverging Trends."

17 Governmental Accounting Standards Board, "Summary of Statement No. 45"; Standard & Poor's Ratings Services, "Diverging Trends," 2; and Governmental Accounting Standards Board, *Other Postemployment Benefits,* 2.

18 Gail Levenson, email communication with The Pew Charitable Trusts, Sept. 22, 2015.

See Appendix D to learn to which retirees these data are applicable, by state. See Appendix A to review the methodology researchers used to determine which groups of retirees were included in the analysis.

19 Centers for Medicare & Medicaid Services, "About RDS," accessed May 26, 2015, http://www.rds.cms.hhs.gov/about/; and Centers for Medicare & Medicaid Services, "Overview of Retiree Drug Subsidy Option" (2005), https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/OviewoftheRDSrev1.pdf.

20 Centers for Medicare & Medicaid Services, "About RDS."

21 U.S. Census Bureau, "Annual Survey of State Government Finances," accessed Feb. 3, 2015, http://www.census.gov/govs/state.

22 McArdle, Neuman, and Huang, *Retiree Health Benefits*; and Centers for Medicare & Medicaid Services, "What's Medicare Supplement Insurance (Medigap)?"

23 Governmental Accounting Standards Board, "Summary of Statement No. 45"; and Standard & Poor's Ratings Services, "Diverging Trends."

24 Government Finance Officers Association, "Considerations for Prefunding OPEB Obligations."

25 Governmental Accounting Standards Board, *Other Postemployment Benefits*, 11.

26 Government Finance Officers Association, "Considerations for Prefunding OPEB Obligations."

27 Standard & Poor's Ratings Services, "Diverging Trends," 1.

28 Ohio Public Employees Retirement System, *Navigating the Future: 2013 Comprehensive Annual Financial Report* (2014), 74–75, https://www.opers.org/pubs-archive/financial/cafr/2013%20CAFR.pdf; Ohio Public Employees Retirement System, "OPERS Board of Trustees," accessed May 15, 2015, https://www.opers.org/about/board/index.shtml; and Arizona State Retirement System, *2013 Comprehensive Annual Financial Report*, 25, 46, https://www.azasrs.gov/sites/default/files/pdf/2013_CAFR.pdf. Although all states assume an amortization period for GASB reporting purposes, many do not contribute payments to fund their OPEB programs based on this assumption.

29 Ohio Public Employees Retirement System, *Navigating the Future: 2013 Comprehensive Annual Financial Report*, 52; Ohio Public Employees Retirement System, "OPERS Board of Trustees"; and Arizona State Retirement System, *2013 Comprehensive Annual Financial Report*, 25.

30 Nebraska does not report an OPEB liability.

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32 Cavanaugh Macdonald Consulting, *Georgia State Employees Post-Employment Health Benefit Fund & Georgia School Personnel Post-Employment Health Benefit Fund Report of the Actuary on the Retiree Medical Valuations Prepared as of June 30, 2013*, 9, 40; Gabriel Roeder Smith & Co., *State of California Retiree Health Benefits Program GASB Nos. 43 and 45 Actuarial Valuation Report as of June 30, 2013*, 14; and Aon Hewitt, *Commonwealth of Massachusetts Postemployment Benefits Other Than Pensions Actuarial Valuation Fiscal Year Ending June 30, 2013, January 1, 2013 Valuation Date*, 2.

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34 Ernst & Young, *Financial Statements, Required Supplementary Information, and Other Financial Information: West Virginia Retiree Health Benefit Trust Fund Years Ended June 30, 2013 and 2012 With Report of Independent Auditors* (2013), 12, http://www.peia.wv.gov/Forms-Downloads/Documents/financial_reports/independent%20auditors%20reports/rhbt/Basic_Financial_Statements_Required_Supplementary_Information_Other_Financial_Information_Fiscal_Years_2012-2013.pdf; and CCRC Actuaries, *State of West Virginia Public Employees Insurance Agency: Analysis of State of West Virginia Defined Benefit Cost-Sharing Multiple Employer Other Postemployment Benefit Plans, GASB 43 and GASB 45 Compliance as of June 30, 2011* (2011), 5, http://www.peia.wv.gov/Forms-Downloads/Documents/financial_reports/opeb/OPEB_Report_6-30-11.pdf.

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36 Aon Hewitt, *State of New Jersey Postemployment Benefits Other Than Pension: Actuarial Valuation July 24, 2012* (2012), 2, http://www.state.nj.us/treasury/pensions/pdf/financial/gasb-43-july2011.pdf; and Buck Consultants, *GASB 45 Actuarial Valuation at 07/01/2011 of the State of Louisiana Post-Retirement Benefit Plan for the Office of Group Benefits* (2012), ii, http://www.doa.la.gov/osrap/library/afr_packetts/2012OGB_OPEBValuationReport.pdf.

37 The Segal Co., *State of Connecticut Other Post-Employment Benefits Program Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of June 30, 2011 in Accordance With GASB Statements No. 43 and No. 45* (2012), 2, http://www.osc.ct.gov/empret/OPEBActuarialReports/OPEBReport2012.pdf.

38 Centers for Medicare & Medicaid Services, "Medicare Program—General Information," accessed May 15, 2015, http://www.cms.gov/medicare/medicare-general-Information/medicareGenInfo/index.html.

39 Ibid.

40 Ibid. To qualify for premium-free Medicare Part A coverage, retirees must have worked and paid into the Medicare program for 40 quarters, or 10 years.

41 Ibid.

42 Centers for Medicare & Medicaid Services, "Part B Costs," accessed May 15, 2015, http://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html; and Centers for Medicare & Medicaid Services, "Ways to Pay Part A & Part B Premiums," accessed May 15, 2015, http://www.medicare.gov/your-medicare-costs/paying-parts-a-and-b/pay-parts-a-and-b-premiums.html.

43 Centers for Medicare & Medicaid Services, "How Do Medicare Advantage Plans Work?" accessed May 15, 2015, http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html.

44 Ibid.

45 Centers for Medicare & Medicaid Services, "How to Get Drug Coverage," accessed May 15, 2015, https://www.medicare.gov/sign-up-change-plans/get-drug-coverage/get-drug-coverage.html.

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47 American Academy of Actuaries, *Measuring Pension Obligations*, 1.

48 Society of Actuaries, "Issues in Selecting the Discount Rate for GASB 45 Valuations," accessed May 15, 2015, https://www.soa.org/library/newsletters/the-actuary-magazine/2007/june/iss2007june.aspx.

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52 Many states have multiple OPEB plans, and researchers aggregated 167 plans to get one set of financial data for each state. (See Appendix A.) GASB Statement 74, "Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans," and GASB Statement 75, "Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions," will replace GASB statements 25, 43, 45, 50, and 57. Governmental Accounting Standards Board, *Statement No. 75 of the Governmental Accounting Standards Board: Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (2015), http://www.gasb.org/jsp/GASB/Document_C/GASBDocumentPage?cid=1176166144750&acceptedDisclaimer=true; and Governmental Accounting Standards Board, *Statement No. 74 of the Governmental Accounting Standards Board: Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans* (2015), http://www.gasb.org/jsp/GASB/Document_C/GASBDocumentPage?cid=1176166143121&acceptedDisclaimer=true.

53 Governmental Accounting Standards Board, "Other Postemployment Benefit Accounting and Financial Reporting."

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62 Ibid., 16.

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65 Ibid.

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67 Ibid.

68 Ibid.

69 Standard & Poor's Ratings Services, "Diverging Trends," 4.

70 McArdle, Neuman, and Huang, *Retiree Health Benefits*, 3.

71 States that did not begin contributing to the Medicare program for their employees until years after the program was implemented have a small number of Medicare-age retirees who are ineligible for Medicare. The costs for these retirees are similar to the cost of early retirees.

72 Coggburn, Daley, and Kearney, "Public Sector Retiree Health Care Benefits," 220.

73 Ibid., 220, 23.

74 Ibid., 223.

75 See, for example, Buck Consultants, *Actuarial Report on the Valuation of the Plan as of June 30, 2013,* Arizona State Retirement System (2014), 86, https://www.azasrs.gov/sites/default/files/pdf/Plan_Valuation.pdf.

76 Gary Claxton and Nirmita Panchal, "Cost-Sharing Subsidies in Federal Marketplace Plans," Henry J. Kaiser Family Foundation (2015), http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans. Cost sharing includes out-of-pocket costs retirees pay, in addition to their premium costs, to cover medical care, including copays, deductibles, and coinsurance. The data reported in this analysis does not include cost-sharing data.

77 McArdle, Neuman, and Huang, *Retiree Health Benefits*, 2, 7–8.

78 Ibid.

79 Ibid.

80 Aaron McKethan, Terry Savela, and Wesley Joines, *What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples From the States,* The Commonwealth Fund (2008), http://www.commonwealthfund.org/usr_doc/McKethan_whatpublicemployeehltplanscando_1097.pdf.

81 David Pratt Ward, *Accounting for the Implicit Rate Subsidy in OPEB Plans,* Society of Actuaries, accessed May 15, 2015, https://www.soa.org/files/sections/Accounting-for-the-Implicit-Rate-Subsidy-in-OPEB-Plans.pdf.

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83 The difference in total premium cost for active employees and early retirees can be substantial. For example, in fiscal 2013, Louisiana did not "blend" its active employee and early retiree health premiums. The total premium for one of its plans was $544 and $1,015 for active employees and early retirees, respectively, for individual coverage. Ward, *Accounting for the Implicit Rate Subsidy*; The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, *State Employee Health Plan Spending: An Examination of Premiums, Cost Drivers, and Policy Approaches* (2014), http://www.pewtrusts.org/~/media/Assets/2014/08/StateEmployeeHealthCareReportSeptemberUpdate.pdf.

See Appendix D to learn to which retirees these data are applicable, by state. See Appendix A to review the methodology researchers used to determine which groups of retirees were included in the analysis.

84 Figures 3 and 4 show the contribution method for Medicare-eligible recent retirees. Idaho, Kentucky, Nevada, Oregon, and West Virginia have changed their contribution method for new hires—Idaho provides no coverage, Nevada, Oregon, and West Virginia provide coverage but no contribution, and Kentucky provides a fixed-dollar contribution. See Appendices C and D.

85 Idaho does not offer health coverage to its existing Medicare-eligible retirees and does not offer coverage to early retirees who were hired after June 30, 2009. However, it does provide coverage and a premium contribution to the early retirees who were hired before July 1, 2009. Indiana and Nebraska do not offer health coverage for their Medicare-eligible retirees.

86 Structures for managing state and local government health care and OPEB liabilities vary from state to state. State CAFRs report OPEB liabilities for health care plans that are run, managed, or financed by the state, which may or may not include local government retiree health care benefits. Byron Lutz and Louise Sheiner, *The Fiscal Stress Arising From State and Local Retiree Health Obligations*, The National Bureau of Economic Research (2014), http://www.nber.org/papers/w19779. Information on the inclusion of local workers in state reports is in their Table A1.

87 Fitch Ratings, *U.S. State OPEB Liabilities: Liability Limited for Most; Uncertain Assumptions Drive Calculations* (2014).

88 Most of the states that prorate their premium contributions use years of service as a prorating factor. Several of these states, and also the remaining states that prorate, use other prorating factors, such as the health plan selected by the retiree, the retiree's age (early retirees), years of state medical plan coverage, or the retiree's final salary.

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90 Idaho does not offer health coverage to its existing Medicare-eligible retirees and does not offer coverage to early retirees who were hired after June 30, 2009. However, it does provide coverage and a premium contribution to the early retirees who were hired before July 1, 2009.

91 Idaho, Indiana, and Nebraska do not offer health coverage to their Medicare-eligible retirees.

92 Idaho and Washington do not offer coverage to their early or Medicare-eligible retirees' dependents. Indiana and Nebraska do not offer coverage to their Medicare-eligible retirees' dependents.

93 Idaho, Indiana, and Nebraska do not provide coverage for their Medicare-eligible retirees. Kentucky did not report data for its Medicare-eligible retiree health coverage type.

94 McArdle, Neuman, and Huang, *Retiree Health Benefits*.

95 Georgia, Illinois, Maine, Minnesota, Ohio, Pennsylvania, Texas, and West Virginia offer only Medicare Advantage plan coverage to their Medicare-eligible retirees.

96 McArdle, Neuman, and Huang, *Retiree Health Benefits*.

97 Ibid.

98 Rak and Kasaraneni, "The Value of Medicare Advantage Employer Group Waiver Plans (MA-EGWPs)."

99 Gail Levenson, interview with The Pew Charitable Trusts, Jan. 23, 2015.

100 Kentucky, Nevada, and Rhode Island are among the states that offer prescription drug coverage or access to prescription drug coverage to their Medicare-eligible retirees; however, data on prescription coverage type are unavailable. Prescription drug coverage is not available to Medicare-eligible retirees in Idaho, Indiana, Mississippi, Nebraska, South Dakota, and Tennessee. Rak and Kasaraneni, "The Value of Medicare Advantage Employer Group Waiver Plans (MA-EGWPs)."

101 May and Liner, "EGWP/Wrap."

102 Ibid.

103 The Medicare Part D coverage gap, known as the "doughnut hole," lies between the initial coverage limit and the catastrophic coverage threshold. After a Medicare beneficiary's costs exceed the initial coverage limit, the beneficiary is financially responsible for a higher cost of prescription drugs until he or she reaches the catastrophic coverage threshold. The ACA reduces the beneficiary's responsibility from 100 percent of prescription drug costs in this coverage gap to 25 percent of the costs. Michael Nadol, Jim Link, and Adam Benson, "Managing Public-Sector Retiree Health-Care Benefits Under the Affordable Care Act," *Government Finance Review*, spring 2014, http://www.gfoa.com/sites/default/files/GFR_APR_14_10.pdf.

104 Centers for Medicare & Medicaid Services, "About RDS."

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105 Barry Eyre and Mark Whitcher, "OPEB Liability—Does It Matter?" *Benefits Magazine*, May 2013, http://www.ifebp.org/inforequest/0163756.pdf; and May and Liner, "EGWP/Wrap." Governmental Accounting Standards Board rules permit states to include subsidies from EGWPs on their balance sheets, reducing their OPEB liabilities.

106 Centers for Medicare & Medicaid Services, *Medicare Prescription Drug Benefit Manual,* Pub. 100-18 (2008), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R6PDB.pdf.

107 Levenson, interview.

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109 Moody's Investors Service, *US Municipal Governments Can Leverage Federal Medicare to Lower OPEB Costs* (2014), http://media.navigatored.com/documents/Medicare+Helping+Muni+Governments+Lower+OPEB+Costs2.pdf.

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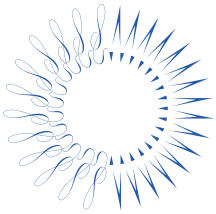

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